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CLINICAL AND EXPERIMENTAL HYPNOSIS**

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EDITORIAL

The May 2006 issue has an applied and practice focus, while that for November will be a special scientific edition on attitudes to, opinions and/or beliefs about hypnosis or hypnotisability.

This edition showcases contributions from South Africa, Denmark, USA, UK and Australia. The topics are diverse and range from childbirth to conversational analysis, and from phantom limb pain to animal visualisation. Some of the articles are papers that were presented at ASH congresses in 2005, and the list of the refereed abstracts for the 2005 ASH Congress appears in this issue before the review section.

Dr Peter Bloom, who has a long association with ASH, has responded to the call for ideas about where hypnosis might be heading, and his thoughts are set out in a special letter to the editor.

Dr Andrew Fiedler volunteers more elucidation about the origins of *Terpnos Logos* and is interested to hear from others on their views.

*Kathryn Gow
May 2006*

LETTERS TO THE EDITOR

To the Editor

When you asked me to comment on the “direction and future of hypnosis in the world,” I immediately thought of the extensive news coverage in the United States on the advances in neuroscience relevant to clinical hypnosis. Amir Raz, PhD at Columbia University, and David Spiegel, MD at Stanford University, are among a number of neuroscientists and clinicians worldwide who are utilising functional magnetic resonance imaging (fMRI) to identify shifts in brain blood flow subsequent to hypnotic suggestions for pain management, perception of colour, and various cognitive tasks including the elimination of the Stroop interference effect.

While clinicians have known for years that hypnotic methods produce startling changes in behaviour, perceptions, and moods, these brain scans in their increasing sophistication allow us to identify the structures of the brain which are involved. I have always regarded hypnosis as a unique modality for investigating the mind–body interface, and the time for rapid advances is now.

The art of therapy is the fusion of scientific understanding and intuitive insight.

To pursue our art, every clinician should identify a neuroscientist and visit him/her in their laboratories. Ignorance is never a virtue; much can be learned and shared during these collaborative visits and subsequent correspondence. We clinicians must wrap our arms around new scientific advances. It assures the future of our patient care and enhances our personal satisfaction.

*Peter B. Bloom, MD,
Editorial Consultant, AJCEH;
Clinical Professor of Psychiatry,
University of Pennsylvania School of Medicine*

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Dear Dr Gow,

Thank you for finally elucidating for me the meaning of our motto!

I would like to comment about the logo, which is not a caduceus, but the staff of Asklepios. The staff is the true symbol of the medical profession, and I believe an appropriate symbol for our society.

The caduceus, which is the winged staff entwined by two snakes, is indeed associated with the messenger god Mercury, or more correctly his Greek equivalent, Hermes.

The confusion between the two is an old one. In the 15th century, printers adopted the caduceus, possibly to reflect their roles as “messengers”, and often books, including medical books and pharmacopeias, were emblazoned with it. More recently, it was erroneously adopted by the American Army Medical Corps, when in 1902 an Army captain thought it a better logo than the cross they had thus far used.

Asklepios was possibly a skilled healer living about 1200 BC. Through myth and legend, he became the Greek demi-god of healing. His cult spread widely throughout Greece and Rome. Many healing or “sleep” temples, or Asklepieia, were built.

One of the most important in Epidaurus is well worth the visit, as it shows how in many ways Greek medicine *was* essentially hypnosis. Patients went through many days of preparation, including baths, massage, music, therapeutic metaphors in the form of theatre — all good trance inducing stuff! Before the final night, they would also be conducted through a frightening subterranean labyrinth (fear being again a great trance inducer), and finally they would sleep in the temple itself. There they were told that as they slept, the god Asklepius and his helpers would come among them to instruct them as to what they must do in order to be healed. Sure enough, this happened, in the guise of masked priests, who would then whisper individual suggestions that the patients’ dreams would reveal their cure. This appears to have been very successful — the minimum fee was a rooster, but many of the magnificent buildings there were donated by grateful patients!

The caduceus was the magic staff of Hermes (Mercury), the god of commerce, eloquence, invention, travel and theft, and so was a symbol of heralds and commerce, not medicine, although there is a medical link with the caduceus through the “Hermetic tradition” of the alchemists, which included the use of pharmaceuticals.

Regards,
Dr Andrew Fiedler

BRIDGING THE GAP BETWEEN PRACTITIONERS AND RESEARCHERS: A CONVERSATION ANALYTIC APPROACH TO HYPNOSIS

Hellene T. Demosthenous
Griffith University

Practitioners have much to contribute to the scientific literature on hypnosis, and researchers are encouraging them to do so. Yet practitioners and researchers often have different views on how the study of hypnosis should be conducted. While practitioners often state that researchers base their findings on controlled and contrived situations that have little to do with real-world clinical practice, researchers stress the need for systematic rigour. To help bridge the methodological gap between practitioners and researchers, this article presents conversation analysis as a suitable method for the systematic and rigorous study of the interactional accomplishment of hypnosis under naturally occurring conditions in real-world clinical practice.

This article presents conversation analysis as a methodological approach to the study of hypnosis. It is *not* concerned with the study of how hypnosis is induced through drugs, or the reading of scripted texts under controlled conditions. Rather, it is concerned with exploring “the way hypnosis is often practised in the ‘real world’” (Lynn, Kirsch, Barabasz, Cardena, & Patterson, 2000, p. 246), that is, *how* hypnosis is *talked into being* (H. T. Demosthenous & Austin, 2003). First, the article presents a rationale for the study of the clinical practice of hypnosis. Second, it acknowledges the difficulty of reaching a generally accepted definition of hypnosis, and explains how that difficulty is in part associated with traditional methods of inquiry. Third, the article introduces conversation analysis as a methodologically distinctive approach to the study of naturally occurring talk and interaction, which has developed

rigorous and systematic procedures that enable reproducible results. In other words, this article presents conversation analysis as an approach that practitioners and researchers can use to carry out empirical studies on *how* the interactional accomplishment of hypnosis naturally occurs in real-world clinical practice.

HYPNOSIS

For over 200 years, practitioners have used “what has been called ‘hypnosis’ or ‘therapeutic trance’” to heal a wide range of health problems (Rossi, 1993, p. xvii), such as asthma (Ewer & Stewart, 1986), burns (Ewin, 1986), enuresis (Edwards & van der Spuy, 1985), pain (Hilgard & Hilgard, 1983), trauma (Spiegel, Hunt, & Dondershine, 1988), and warts (Ewin, 1992). Given the value of hypnosis as a healing phenomenon, a lot of research has been conducted and hypnosis has acquired the status of an empirically supported and cost-effective clinical intervention (Lynn et al., 2000).

Yet, despite its scientific advance, “it has been impossible to find general agreement among professionals on just exactly what hypnosis is” (Rossi, 1993, p. xvi–xvii). The problems associated with defining hypnosis have, no doubt, been complicated by the fact that the term *hypnosis* refers to both the strategic techniques that are used to accomplish the phenomenon and to the phenomenon itself (Barber, 2000). In any event, attempts to define hypnosis have resulted in the postulation of numerous theories which differ from — and converge with — one another in various ways (Lynn & Rhue, 1991). So it is little wonder that scholars of hypnosis have pointed out that “[t]he danger we face is the temptation to overgeneralise in theory before the phenomena are really in hand” (Sheehan & McConkey, 1996, p. xi).

Further to this, it has been suggested that the difficulty in agreeing on a definition of hypnosis is partly associated with the fact that hypnosis research has overwhelmingly focused on explaining the experiences and actions of *only* one of the individuals involved in the hypnotic encounter (Bányai, 1998; Diamond, 1987; Haley, 1958). As Bányai (1998, p. 52) has commented:

this lack of agreement regarding the definition of hypnosis may be due partly to the fact that historically the hypnosis literature has been concentrating either on the so called “magnetic power” and the skill of the hypnotist (like Mesmer and, recently, *the disciples of M. H. Erickson* [italics added]) or on the hypnotic ability and the talent of the subject (like Charcot and the authors of the modern hypnotic susceptibility scales).

So, it is little wonder that scholars of hypnosis have also pointed out that “we should consider that *hypnosis develops in a unique interaction between hypnotist and subject*, and we should study the interaction itself” (Bányai, 1998, p. 53; Haley, 1958).

Experimental Research on Interaction

While the overwhelming concern with an individual level of analysis seems somewhat difficult to justify, experimental research on the interactional basis of hypnosis has been complicated by the controlled conditions under which the hypnotist works. As Bányai (1998, p. 57) mentions, under “standardised experimental conditions the hypnotists are restricted in many ways.” Of course, this does not mean that the interactional development of hypnosis is *restricted* in every instance, but it does seem likely that it may be so. In addition, the restrictions imposed upon the hypnotist may also be associated with the difficulty of reaching a commonly accepted definition and theory of hypnosis.

As stated earlier, practitioners and researchers often have different views on how the study of hypnosis should be conducted. Practitioners call for studies that are based on *actual* practice, and raise concerns over the fact that researchers tend to base their findings on controlled and contrived situations that have little to do with real-world clinical practice (practitioners’ comments at the 35th Annual Congress of the Australian Society of Hypnosis). On the other hand, researchers emphasise the need for studies that are based on systematic rigour and critique those who prefer to rely “on cherished beliefs, revered authority, or dramatic, unsubstantiated anecdote” (Nash, 2000, p. 107). A means by which we might bridge the methodological gap between practitioners and researchers is through the approach of conversation analysis.

CONVERSATION ANALYSIS

Conversation analysis, or CA as it is commonly called, is an area of inquiry that is oriented towards understanding the organisation of naturally occurring interaction between people in real-world settings (Heritage, 1984). CA developed within the ethnomethodological tradition in sociology, and emerged in the 1960s through the pioneering work of the late Harvey Sacks and his colleagues, Emanuel Schegloff and Gail Jefferson (Heritage, 1984).

Since those early days, conversation analysis, or the study of talk-in-interaction as it is also known, has devised a number of basic theoretical and

methodological assumptions, as well as its own unique terminology. According to Heritage (1995, p. 394–397), the basic assumptions of conversation analysis are:

1. *The primacy of ordinary conversation* “Ordinary conversation” between peers represents a fundamental domain for analysis, and a basic resource for the extension of CA into other “non-conversational” domains. Research has found that ordinary conversation differs in systematic ways from, for example, practices of communication in legal and medical institutions, where task objectives generally involve a reduction in the range of behaviour that is usually found in ordinary conversation (Drew & Heritage, 1995b).
2. *The use of naturally occurring recorded data in conversation analysis* CA is insistent on the use of recordings of naturally occurring data as the empirical basis for analysis. This is because naturally occurring recorded data provide a permanent record that can be transcribed and re-transcribed with the aim of recovering and reproducing the detail of the *actual* interaction under study. Further, the use of recorded data together with the availability of transcripts enables others to check the validity of the claims being made, while the recording of naturally occurring data (instead of data that is controlled and contrived for the purpose of study) ensures the validity of interactions as possible events in the real world (which, as mentioned earlier, is something that practitioners at the 35th Annual Congress of the Australian Society of Hypnosis have called for).
3. *The structural analysis of conversational practices* Social interaction is informed by structural organisations of practices to which participants are normatively oriented. CA searches for structural organisations of interactional practices in a particular way. That is, like ethnomethodology, CA adopts the stance of “indifference” (Garfinkel, 1967), in that it abstains from taking any position on what constitutes the phenomenon under study, and gives prominence to co-participants’ understandings of their own and each others’ behaviours. In other words, CA sets aside preconceived theories and conceptual categories in favour of exploring the phenomenon under study in fine detail, which is something that hypnosis researchers have advocated (Sheehan & McConkey, 1996).

A Method Suited to Interdisciplinary Study

Although conversation analysis originally grew out of the field of sociology, its nature is interdisciplinary. As Schegloff (1991) comments: “CA is at a point

where linguistics and sociology (and several other disciplines, anthropology and psychology among them) meet” (p. 46). In fact, when Sacks first developed CA’s focus on the sequential organisation of conversation, he did so by studying recordings of telephone calls made to a suicide prevention centre and recordings of group psychotherapy sessions (Sacks, 1992a, 1992b).

Sacks’ pioneering work on the sequential organisation of “ordinary” conversation between peers in everyday settings (Sacks, Schegloff, & Jefferson, 1974) has given rise to many empirical studies on “specialised” talk between professionals and lay persons in a variety of institutional settings including the courts (Atkinson & Drew, 1979), the classroom (Mehan, 1979), and indigenous student support meetings (Demosthenous & Demosthenous, 2004). Further, a growing number of analysts have focused on the coordination of talk and *nonvocal* aspects of conversation between peers (Goodwin, 1981) and “specialised” talk between professionals and lay persons in medical consultations (Heath, 1986) and the hypnosis session (Demosthenous & Austin, 2003), for example. Thus, the name *conversation analysis* is something of a misnomer, because it has been “applied to interactions which are evidently not ‘ordinary conversation’” (Drew & Heritage, 1995a, p. 4).

Methodological Preliminaries

The following section outlines a brief consideration of some of the methodological preliminaries relevant to a conversation analytic study of hypnosis, including the transcription conventions. It is based on some preliminary observations from a pilot study that was conducted to inform the direction of the author’s doctoral research. Notable findings were that speech and nonvocal actions were significant to the interactional development of a hypnotic trance, and that, therefore, the study of both audio and visual data was essential to an understanding of interaction between hypnotist and patient in real-world clinical practice (Demosthenous, 2005).

Transcription System

The transcription system for talk was devised by Gail Jefferson (Heath, 1986, p. ix) (for details, see Sacks et al., 1974). The transcription system for talk permits the analyst to represent the sequential order of how people take turns talking, where they pause, when they talk, and where they interrupt each other during the talk. It also allows the analyst to record intonation, pace, and other vocal aspects of interaction.

As mentioned earlier, a sequential analysis can be extended to encompass an analysis of the coordination of speech and body movement. Goodwin (1981) devised the transcription system for nonvocal aspects of interaction (such as, gaze direction). This system allows the analyst to capture a visual representation of the lengths of silences when people talk. It also allows the analyst to detail how people use body movement (such as altering gaze direction) during interaction. A list of the transcription symbols for talk and nonvocal action and their explanations is provided in Table 1.

Table 1: Transcription System

Sequencing	
=	<i>Equal signs</i> , one at the end of one line and one at the beginning of a next, indicate no “gap” between the two lines.
Timed intervals	
(0.0)	<i>Numbers in parentheses</i> indicate elapsed time in silence by tenth of seconds, so (7.1) is a pause of 7 seconds and one-tenth of a second.
(.)	<i>A dot in parentheses</i> indicates a tiny “pause” within or a “gap” between utterances.
Characteristics of vocal production	
word	<i>Underscoring</i> indicates some form of stress, via pitch and/or amplitude; an alternative method is to print the stressed part in italics.
::	<i>Colons</i> indicate prolongation of the immediately prior sound. Multiple colons indicate a more prolonged sound.
,	Punctuation marks are used to indicate characteristics of speech production, especially intonation; they are not referring to grammatical units; e.g., a comma indicates a continuing intonation, such as when you are reading items from a list.
↑↓	<i>Arrows</i> indicate marked shifts into higher or lower pitch in the utterance-part immediately following the arrow.
Characteristics of nonvocal production	
_____	<i>A continuous line</i> immediately above or below the transcribed talk and/or silence represents gaze.
•	<i>A filled circle</i> in the line of gaze indicates blinking. A row of filled circles indicates eye closure.
↑↓	<i>A doubled headed vertical arrow</i> above or below the transcribed talk and/or silence indicates head nodding.

Pilot Study Data

This section initially describes the pilot study data that were used to inform the research design of my doctoral study on the accomplishment of hypnosis. Recall that CA is insistent on the recording of naturally occurring (or non-experimental) data.

The pilot data comprised part of a hypnosis session taken from a commercially available audiovisual recording entitled *The Artistry of Milton H. Erickson, M.D.*, that was made in the USA in 1975 (Lustig & Pyle, 2000). The examples that follow illustrate how CA is able to describe hypnosis as an interactional accomplishment.

Vocal Aspects

In the first example, vocal aspects of a hypnotic trance induction are provided. As is common practice in CA, the first column in Example 1 represents the various lines of transcribed talk, with each line numbered for analytic reference. The second column identifies the speaker by profession, with the initial “H” for hypnotist. The third column represents the details of talk in the hypnotic trance induction sequence.

The hypnotic trance induction sequence opens with a lengthy four seconds and nine-tenths of a second silence (4.9). The hypnotist (H) then instructs the primary patient (P) that he would “like” her to go into a trance slowly and that he does not “want” her “to go into a trance too soon” (lines 2–5). Thus going into a hypnotic trance is specified as an activity that the primary patient does and that the hypnotist has rights of control and preference over.

Vocal actions only are made available in this transcript and, using only these, it appears that the hypnotist assumes and is afforded sole rights to the talk. His talk appears as a monologue interspersed with silences, that is, the talk and silences alternate, forming a turn-taking pattern. In addition, the hypnotist retakes the talk without orienting to, or dealing with, the primary patient’s failure to speak in any way. According to Pomerantz (1992, p. 152), “[i]f a recipient does not give a coherent response, the speaker routinely sees the recipient’s behaviour as manifesting some problem and deals with it.”

However, this is not the case here. Instead, the participants appear to mutually orient to the *talk-and-silence-turn-taking* pattern as reasonable (or normative) for this particular social activity. For instance, at line 17 the hypnotist makes known that he “hears” in the primary patient’s actions that she is in, or at least going into, a hypnotic trance with the directive: “Not quite that(.) fa:s’ Monde.”

Then, at line 38, the hypnotist provides the primary patient with a clear guide for her actions: “↓now go deeply=into=th:’=↓tra::nce:;” and we learn that the hypnotist “hears” in the primary patient’s actions that she has complied with his directions for the activity of going into a hypnotic trance.

Example 1: A Hypnotic Trance Induction Sequence

[0101] (H = Hypnotist)

Line	Id	Interaction
1		(4.9)
2	H:	W’ll=Monde this t↑i::me (0.7) I’d like t’ have
3		you take yer time abou’ go:ing into a tra:nce
4		(0.9) I don’t want tu t’=go <u>into</u> =a tra:nce
5		↑too=↓so↑o::n:
6		(1.8)
7		An’ y’know how ea:sy it ↑i:s fer yer,
8		(1.1)
9		And while Nick=is her:e
10		(0.7)
11		I’d like to have=you=wa:tch how Monde’s fa:ce
12		(1.4)
13		And yer=unconscious mind will <u>lear::n</u> a great
14		deal °s’° tu:rn, ‘n’ <u>look</u> (0.2) s’=yo’=c’n
15		see=’er.
16		(3.4)
17		Not quite that (.) fa:s’ Monde.
18		(0.8)
19	?	((laughter))
20		(0.9)
21		Lets=↓hava=liddle ta:lk (.) fi:rs’
22		(1.3)
23		‘cause in the trance I will ↓wa::nt (.) you:
		.
		.
		.
37		(3.6)
38		<u>↓now go deeply=into=th:’=↓tra::nce: ...</u>

This is learned from the positioning of the hypnotist's utterance (in line 17) in relation to his immediately prior utterance (to the *primary patient* in line 7). Thus the hypnotist's "utterances gain their character and interactional significance through their position in a developing stretch of talk and in particular with reference to the immediately prior utterance and utterances," as is the case in other forms of naturally occurring interactions (Heath, 1986, p. 10).

In general, conversation analytic studies of audiovisual data tend to take the vocal production by participants as a baseline for understanding interaction (ten Have, 2000). However, since the primary patient did not speak throughout the production of this hypnotic trance induction sequence, it was *impossible* to determine the character of the interaction from the audio data alone, and therefore it was not possible to take the vocal production by the participants as a baseline for understanding the hypnotic trance induction sequence. In order to make sense of the hypnotist's utterances and with a view to determining the primary patient's part in the interaction, *both* vocal and nonvocal aspects of the data were documented and examined.

Vocal and Nonvocal Aspects

In the following examples, vocal and nonvocal aspects of the hypnotic trance induction are provided together. Note that lines 7, 8 and 9 of the hypnotist's transcribed talk and the durations of silence (from Example 1) are reexamined with the client's associated nonvocal responses (see Examples 2, 3 and 4). Note, further, that lines 21, 22 and 23 of the hypnotist's transcribed talk and the durations of silence (from Example 1) are also examined with the client's associated nonvocal responses (see Example 5). In these examples, the first column represents the identity of the hypnotist (H) or the primary patient (P). The second column represents details of simultaneous vocal and nonvocal interaction between H and P during these moments of the hypnotic trance induction sequence.

Only a few moments of the hypnotist's multi-utterance turn in the hypnosis session are examined. These are the moments that demonstrate the appropriateness of the hypnotist's utterances; through the import of selected nonvocal aspects of the primary patient's interaction. The nonvocal focus within the turn is primarily on gaze.

As Goodwin (1981) found, *gaze* is one way in which co-participants can orient to one another within the turn-taking during ordinary

conversation. Note that the gaze behaviour of the co-participants in this work is particular to the study of hypnosis.

For that reason, I have expanded the methodology by developing a set of transcription symbols. Relevant to the following analysis are the *filled circle* (•) and the *doubled headed vertical arrow* (‡). The *filled circle* was developed to indicate that the line of gaze is interrupted as the gazing participant blinks or closes their eyes momentarily (___•___). *Filled circles* (•••••) indicate eye closure. The *continuous line* (_____) in the vocal with nonvocal transcripts (see Examples 2–5) represents gaze behaviour. The length of the row of filled circles indicates the length of the eye closure. In addition, a *doubled headed vertical arrow* (‡) indicates the up and down nodding of the head (for further details see Table 1).

Example 2: An Act of Hearing

[0101] (H = Hypnotist, P = Primary patient)

Lines 7–9

(H out of camera)

H: An' y' know how ea:sy it †i:s fer yer,-----And

P: _____•____••____•_____

Recall that the hypnotist has been instructing the primary patient on how he would “like” her to proceed with the activity of going into a trance. At line 7, the hypnotist *praise assesses* the primary patient’s ability to do so. An examination of the visual data around the hypnotist’s *praise assessment* of the primary patient’s hypnotisability shows that the primary patient gazes intensely at the hypnotist throughout the production of this assessment and beyond, and that both the primary patient and the hypnotist orientate to this gaze behaviour as reasonable for the induction of hypnotic trance. Other studies have shown that a non-speaker can act like a listener by gazing at a speaker (Goodwin, 1981; Heath, 1986), but in *non-hypnotic* interaction, gaze is normally held for brief durations. Here the primary patient continues to gaze intensely at the hypnotist even after blinking (•), and the primary patient does not divert her gaze from the hypnotist at this, or any other, time during the hypnotic trance induction. It is proposed that the hypnotist in all probability “hears” the primary patient’s prolonged gaze throughout the praise assessment *as an act of hearing* his talk, and that the hypnotist designs his talk not only on the basis of past experience(s), but also on the basis of this hearing.

Example 3: An Act of Understanding

[0101] (H = Hypnotist, P = Primary patient)

Lines 7–9

(H out of camera)

H: An' y' know how ea:sy it i:s fer yer,-----And



As the hypnotist’s praise assessment of the primary patient’s ability to go into a hypnotic trance comes to a close the primary patient produces a number of head nods (↓) at blink-related points (•) in the production of her gaze (_____) at the hypnotist. Other research has shown that “[b]ecause of their placement at particular points in the talk, actions such as these head nods enable a recipient to display, not simply hearership, but some aspect of his [sic] understanding of the talk then being produced” (Goodwin, 1981, p. 103). Based on the positioning of these head nods, it is likely that the hypnotist “hears” the primary patient’s head nodding *as an act of understanding* his praise assessment of her hypnotisability. So the hypnotist designs his talk not only on the basis of past experience(s), but also on the basis of this understanding.

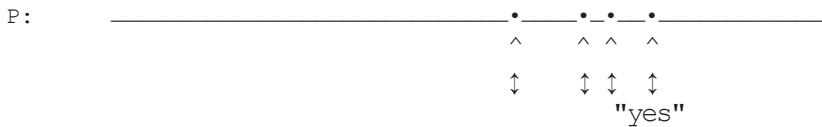
Example 4: An Act of Agreeing

[0101] (H = Hypnotist, P = Primary patient)

Lines 7–9

(H out of camera)

H: An' y' know how ea:sy it i:s fer yer,-----And



Following the hypnotist’s praise, assessment is a one-second gap in the talk. At roughly five-tenths of a second into the gap the primary patient’s head nodding culminates in a slightly larger nod, as she simultaneously mouths the word “yes.” With this yes-nod, the primary patient co-participates with a “preferred action” (see, e.g., Goodwin & Heritage, 1990, for a discussion of preferred actions and dispreferred actions) as she agrees with the hypnotist’s praise assessment of her trance “know how” (line 7). The primary patient’s nonvocal response has apparently been seen and treated by the hypnotist as a turn, as his actions show no “marking” of her apparent failure to take a turn. The primary patient’s nonvocal action is positioned where a turn transition is hearable and “heard” by the hypnotist (and analyst) as the primary patient’s

her “time about going into a trance.” (lines 2–3). In any event, it suggests that the hypnotist has “heard” the primary patient’s closed eyes as an indicator of hypnotic trance. This further suggests that the hypnotist “hears” the primary patient’s gaze behaviour as *an act of complying*. That is, at this point in the interaction the hypnotist reads the primary patient’s eye closure as complying with going into a hypnotic trance, and her eye opening as delaying the further production of a hypnotic trance. Note also that the hypnotist designs his talk not only on the basis of past experience(s) (by indirectly referring to the primary patient’s previous hypnotic trance know-how), but also on the moment-to-moment basis of the primary patient’s current doing.

Given those considerations one may conclude that the hypnotist’s utterance (“Not quite that (•) fa:s’ Monde,” line 17) gains its character and interactional significance from his own immediately preceding utterance to the primary patient (“An’ y’know how ea:sy it †:is fer yer,” line 7) and the primary patient’s following action (closed eyes during the talk at line 21). The fact that the primary patient’s eyes open when the hypnotist directs her to delay the further production of a trance shows that her eye closure is what the hypnotist “hears” as determining the activity as a hypnotic trance. Further, from the positioning of the primary patient’s actions in relation to the hypnotist’s talk, we learn that the primary patient hears, understands, and agrees to comply with what the hypnotist’s guide for her actions directs — *going into a hypnotic trance*.

CONCLUSION

In the hypnotic interaction studied here, it is arguable that the hypnotist progressively bases the hypnotic trance induction upon how the primary patient makes sense of, and reacts to, his talk on a moment-to-moment basis; that is, an arguable case for the sequential turn-by-turn ordering of nonvocal and vocal action. Simply, the pilot study has established that turn-taking in the hypnotic trance induction consists of vocal turns and nonvocal turns. Specifically, the pilot study revealed that the hypnotist uttered directives to the primary patient, and the primary patient non-vocally demonstrated to the hypnotist (and the analyst) that she could hear (gaze), understand (head nods), agree (yes-nod), and comply with the hypnotist’s guide for hypnotic trance (eye closure). In addition, participants mutually oriented to these actions as reasonable, and there is therefore clear evidence of interaction throughout the hypnotic trance induction phase of the hypnosis session. However, it raises the issue of whether any of the features of interaction examined here are

idiosyncratic and consequential to the induction of hypnosis in general, or deep hypnosis in particular.

Finally, this article has introduced conversation analysis as a methodological approach to the empirical study of how hypnosis naturally occurs in real-world clinical practice. As such, it has been argued that CA provides us with a new way of studying hypnosis as an interactional accomplishment, and a way in which we might bridge the methodological gap between practitioners and researchers of hypnosis.

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A COMPARISON OF MIDWIVES' KNOWLEDGE OF, AND ATTITUDES TO, HYPNOSIS IN HOSPITALS WITH AND WITHOUT A HYPNOTHERAPY SERVICE

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A cross-sectional survey of midwives' knowledge of, and attitudes to, hypnosis, in hospitals with (CH) and without (NCH) a clinical hypnotherapy service was undertaken. A 28-item questionnaire was distributed to a random sample of midwives at the two hospitals. The overall response rate was 118 out of 130 midwives (91%). Compared with NCH, CH midwives were more likely to support the use of clinical hypnosis ($p < 0.001$) as being helpful during childbirth ($p < 0.001$), and to recommend hypnosis as an analgesic adjunct during childbirth ($p < 0.001$). CH midwives were also more likely to express an interest in hypnotic techniques being taught during midwifery training ($p < 0.003$). The vast majority of respondents (83%) agreed that positive suggestion techniques should be taught during midwifery training.

The use of hypnosis in obstetrics has been practised for more than a century (Werner, Schauble, & Knudsen, 1982) and there is increasing evidence that it is an effective form of pain relief in labour and may be associated with other benefits such as a decrease in the need for labour augmentation and an increased incidence of spontaneous vaginal delivery (Cyna, McAuliffe, & Andrew, 2004). There is anecdotal evidence of hypnosis reducing the incidence of post-partum depression (Werner et al., 1982) and anxiety (Goldman, 1992) and it may increase maternal satisfaction with the childbirth

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experience (Freeman, Macaulay, Eve, & Chamberlain, 1986). The expectant mother can be taught skills for anxiety management through the use of self-hypnosis (Schauble, Werner, Rai, & Martin, 1998) and it has been claimed that receptivity to suggestion and hypnosis increases during pregnancy by approximately 30% (Tiba, 1990), while Spiegel emphasises how stress increases the response to suggestion (Spiegel & Greenleaf, 1963).

A recent Cochrane review (Hodnett, Gates, Hofmeyr, & Sakala, 2003) demonstrated that with continuous support during labour, women were less likely to require intra-partum analgesia, operative birth, or to report dissatisfaction with their childbirth experiences. Interestingly, the intervention of continuous support in this review (Hodnett et al., 2003) involved the use of positive awake suggestions during labour. Newbold (1950) was probably the first to endorse the teaching and use of hypnosis by midwives and its use has recently begun to be appreciated in the United Kingdom (Wainer, 2001). However, midwives' attitudes to, and knowledge of, clinical hypnosis during childbirth are factors that warrant further exploration. A few studies of patients' beliefs and attitudes to hypnosis have been reported (McIntosh & McIntosh, 1983), as well as those of the general public (Johnson & Hauck, 1999), university students (Channon, 1984; Wilson, Greene, & Loftus, 1986), and anaesthetists (Coldrey & Cyna, 2004; Scott, 1983).

A recent Australian study has explored midwives' use of complementary therapies (including hypnotherapy) during pregnancy (Gaffney & Smith, 2004). In view of increasing anecdotal interest in the utilisation of hypnosis in childbirth by midwives at our institution and elsewhere (Wainer, 2001), it was planned to compare midwives' attitudes to, and knowledge of, hypnotherapy in childbirth in two maternity hospitals. One hospital had clinicians utilising hypnosis as an adjunct to other therapeutic measures in childbirth while the other maternity unit had no hypnotherapy service.

METHOD

The survey was conducted in the two largest tertiary maternity units in South Australia. One hospital with a clinical hypnosis service (CH) had a two-year history of using hypnosis in pregnancy and during childbirth, whereas the other hospital had no clinical hypnosis service (NCH) in the childbirth setting. Questions assessing midwives' knowledge and experience of hypnosis were based on similar published studies on this topic (Channon, 1984; Johnson & Hauck, 1999; Wilson et al., 1986). The questions covered

attitudes and knowledge of clinical hypnosis, interest in training in hypnosis, previous experience(s) with clinical and non-clinical hypnosis and their effects on midwives' perceptions of hypnosis. The survey also included a section on attitudes towards training and the use of positive suggestion in midwifery clinical practice. A pilot study of midwives at CH and at NCH in the childbirth setting was performed to permit power calculation and modification of the questionnaire. This pilot study showed a need for some clarifications of the questions. Both hospitals' local regional ethics committees gave approval for the study.

In June 2004, the revised survey form, containing 28 items, was distributed. All participating midwives gave informed consent prior to receiving a questionnaire. Surveys were completed by midwives in the presence of a researcher (Y.H.E.) where possible, in order to minimise losses of forms. The remainder were left on the ward for completion by the midwife and collected later.

Power of Study and Analyses

The pilot showed that 10/12 CH midwives (83%) thought hypnosis helpful while only 38% of NCH midwives responded in this way. Pilot response data of midwives' attitude to hypnosis were entered onto the EpiInfo V6™ computer program which calculated that 51 participants would be required at each hospital to show this difference with a power of 95% at $p < 0.05$ level. Other questions in the survey that might show smaller differences were considered, and in order to account for data losses or late returns of the survey a total of 130 questionnaires were distributed. Survey data were transcribed on to a computer spreadsheet (Excel™) and presented as descriptive statistics with chi squared analysis and t tests where appropriate. Where questions were not adequately completed, data were excluded from descriptive statistics calculations and the number of respondents to a particular question shown in the tables below. Several midwives selected more than one area as their main location of work within the hospital. Those respondents who had listed either labour ward or birthing centre as one of their main locations of work were placed in the labour and birthing centre group. Participants who stated they were "rotating" were placed in the ward where the questionnaire was administered. Subsequent analyses were performed without any identifiers of the respondents. Exposure to hypnosis detailed in the results was defined as midwives witnessing and/or experiencing hypnosis.

RESULTS

A total of 118 of the 130 questionnaires (91%) distributed to midwives were returned. Demographic data of the midwife participants at each hospital are shown in Table 1.

Comparison of midwives at the two hospitals demonstrated that there were no significant differences regarding respondents' gender, age, years worked as a midwife, or main location of work.

Table 1: Midwife Participants' Demographic Data

	CH midwives (<i>n</i> = 59)	NCH midwives (<i>n</i> = 59)
Gender male/female	1/58	1/58
Mean age in years* (<i>SD</i> , range)	43.3 (8.5, 24-58)	41.7 (10.2, 22-61)
No. yrs worked as midwife** <i>X</i> (<i>SD</i> , range)	16.8 (8.6, 1-39)	15.1 (9.9, 0.33-40)
Main location of work***		
Labour ward or birthing centre	31 (52%)	26 (44%)
Antenatal ward	14 (24%)	18 (31%)
Postnatal ward	8 (14%)	10 (17%)
Other wards (i.e., SCBU + NICU)	6 (10%)	5 (8%)

Note: SCBU = Special care baby unit; NICU = Neonatal intensive care unit.

* $p = 0.389$, ** $p = 0.338$, *** $p = 0.740$.

Table 2 shows the differences reported by CH and NCH midwives regarding their experience of hypnosis. Although most midwives had witnessed clinical hypnosis used as an adjunctive labour analgesia, others had witnessed its use in the control of hyperemesis, control of anxiety and panic disorders, induction of labour, stop-smoking programs, and assistance with other analgesia.

Table 2: Differences in CH and NCH Midwives' Previous Exposure to Hypnosis

	CH midwives (<i>n</i> = 59)	NCH midwives (<i>n</i> = 59)
Witnessed clinical hypnosis *	35 (59%)	13 (22%)
Witnessed non-clinical hypnosis	26 (44%)	34 (58%)
No previous exposure to hypnosis **	6 (10%)	19 (32%)

* $p < 0.0001$, ** $p < 0.01$.

Table 3 shows the midwives' reported attitudes to hypnosis. There was no difference between the midwife groups regarding exposure to non-clinical hypnosis, or the number of midwives having personal experience of clinical hypnosis. Following the witnessing of clinical hypnosis, 33 of the 35 CH respondents (94%) and 7 of the 13 NCH midwives (54%) reported it as a positive effect ($p < 0.01$).

Table 3: Attitudes Towards Clinical Hypnosis Among Midwives in CH and NCH

	CH midwives (n = 59)			NCH midwives (n = 59)		
	Yes	No	Don't know	Yes	No	Don't know
Supports clinical hypnosis*	52 (88%)	0	7 (12%)	34 (58%)	4 (7%)	21 (36%)
Hypnosis helpful in childbirth*	45 (76%)	0	14 (24%)	25 (42%)	7 (12%)	27 (46%)
Hypnosis recommended as analgesic adjunct in childbirth*	53 (90%)	0	6 (10%)	34 (58%)	9 (15%)	16 (27%)
Interest in training in hypnosis**	42 (71%)	5 (8%)	12 (20%)	25 (42%)	14 (24%)	20 (34%)

Note: Compared with NCH, CH midwives responses were significantly more likely to have a positive response.

* $p < 0.001$, ** $p < 0.003$.

Table 4 shows the participants' perceived knowledge level of hypnosis. From the choice of available definitions, 87% of midwives correctly indicated on the survey that the best definition of hypnosis was "a state of consciousness similar to meditation." Eleven of the 57 midwives (19%) who had previously been exposed to clinical hypnosis and 9 of the 25 midwives (36%) with no previous exposure perceived a loss of voluntary control when hypnotised. There were no differences in this respect between midwives at CH and NCH units. The majority of midwives from both CH (76%) and NCH (39%) units reported they had mainly obtained their knowledge of hypnosis from the clinical setting, while 14% and 32% respectively had obtained their knowledge in the non-clinical setting. The vast majority of respondents (83%) agreed that positive suggestion techniques should be taught during midwifery training.

Table 4: Midwives' Reported Perceived Knowledge Level of Hypnosis

	CH midwives (n = 59)	NCH midwives (n = 59)
Extensive knowledge	15 (25%)	10 (17%)
Know something	34 (58%)	25 (42%)
Little knowledge*	10 (17%)	24 (41%)

* $p = 0.004$.

DISCUSSION

This report is the most comprehensive survey of midwife knowledge of, and attitudes to, hypnosis performed to date. It is also the first study to compare midwives' attitudes and knowledge between institutions with and without a clinical hypnotherapy service in the childbirth setting. Despite similar demographic data of midwives in the two institutions, clear differences in midwife attitudes to hypnotherapy were evident. CH and NCH midwives were comparable populations, thus any differences in attitudes and knowledge of hypnosis found in this study were likely to be due to the difference in the level of exposure to hypnosis between the two hospitals. Compared with NCH, CH midwives were more likely to have been exposed to clinical hypnosis. This probably reflects the two-year history of the use of clinical hypnosis within that institution. Exposure to clinical hypnosis generally had a positive effect on respondents, although this is more pronounced with CH midwives. It appears that personal experience in non-clinical hypnosis mainly had a positive effect on the respondents. However, witnessing non-clinical hypnosis had a more negative effect. Three participants who reported negative effects after witnessed non-clinical hypnosis believed non-clinical hypnosis was "degrading."

The majority of midwife respondents were supportive of the use of clinical hypnosis. None of the CH participants were unsupportive of clinical hypnosis, while 11% of NCH midwives did not support the use of clinical hypnosis in childbirth. Differences in attitude and experience with clinical hypnosis are clearly reflected in both the number and nature of the comments made by the two groups of midwives as detailed in Figure 1.

Interestingly, none of the 35 CH midwives who had witnessed clinical hypnosis reported a negative effect on attitude, whereas 5 of the 13 NCH respondents (38%) who had witnessed clinical hypnosis reported a negative effect. Of the six respondents reporting personal experience in non-clinical hypnosis, five (83%) reported positive responses, and one (17%) reported that the experience did not affect her perception of hypnosis. Those who had witnessed non-clinical hypnosis were more likely to have a negative experience than those who had witnessed clinical hypnosis.

The reason for midwives' interest or disinterest in hypnotic training was not explored; one CH participant stated the reason for her not supporting the teaching of clinical hypnosis during the midwifery training program was because "hypnosis requires extensive training beyond the realms of midwifery

training.” The perception that the hypnotist has control of the hypnotised person was a common misconception held by respondents who had only been exposed to non-clinical hypnosis. This suggests that entertainment media utilising hypnosis may fuel negative images of hypnosis and deter some healthcare workers and patients from its therapeutic uses. In both hospitals, there was an apparent discrepancy between the number of participants who reported previous exposure to clinical hypnosis and those reporting the clinical setting as their main source of knowledge of hypnosis. Only 38 CH participants reported previous exposure to clinical hypnosis, despite 45 midwives reporting that their main source of hypnosis knowledge had been from clinical experiences. Similarly in NCH, 19 participants reported previous exposure to clinical hypnosis, yet 23 had indicated that their main source of hypnosis knowledge had been acquired from clinical experiences. The most likely explanation for this discrepancy is that midwives working in hospitals may acquire knowledge of clinical experiences indirectly, through communication with colleagues or at in-service lectures.

The survey had included questions asking the participant whether hypnosis was helpful in five areas of childbirth previously reported to be of value. The response options were “yes” and “no,” although perhaps a third option of “don’t know/undecided” should have been added, as many midwives opted for this answer. Participants were asked for their responses after personal experience or witnessing clinical and non-clinical hypnosis. In future studies it would be useful to ascertain the reason for positive and negative responses to clinical hypnosis that were not explored in this study.

Despite differences in the level of exposure between these two groups of midwives, it was shown that their knowledge and attitudes towards hypnosis were generally in favour and supportive of its use. However, compared with NCH, more CH midwives expressed a positive attitude to its usefulness and were more interested in the inclusion of hypnosis in midwifery training. Nevertheless, a large majority of midwives expressed an interest in the inclusion of positive suggestion techniques as part of midwifery training. Further research would need to be conducted to determine the exact nature of that training.

Figure 1: Comments Made by Midwives at CH and NCH Units

CH midwives' comments	NCH midwives' comments
<p>Observation of hypnosis</p> <p>Very impressed with all hypnosis I have observed ... Positive suggestion is a very effective way to help women cope with their contractions. Positive suggestion — strongly agree with this!</p> <p>I believe hypnosis has its place in childbirth ... May be effective for some women especially if pre-taught antenatally ... The woman still allowed to use other forms of analgesia when hypnosis failed</p> <p>It is heartening to see hypnosis being employed in the public hospital setting for childbirth and is viewed very favourably by clientele</p> <p>I have worked with patients on the antenatal ward who have had hypnotherapy and the results have been amazing. I fully support the use of it in the clinical setting</p>	<p>None</p>
<p>Opinions expressed</p> <p>Positive thinking + the psyche is already a very large component of antenatal care + education classes. I think most midwives are aware. I think hypnotherapy is a very individual need + a small majority of women would value from it. To be effective, the woman would have to be susceptible to it. I don't think the value would be widespread</p> <p>I think anything that could prevent invasive procedures + pharmacological pain relief should be considered. I think positive suggestion is an essential part of routine care</p> <p>I support hypnosis for women in labour if it is working for that woman</p> <p>I strongly support hypnosis. I would be happy to be involved in both research and practice</p> <p>I must admit I don't know a lot about hypnosis but I think if it is effective in pain relief/relaxation in birth, I think wonderful!</p> <p>Positive suggestion techniques have been used for years by some midwives (old school)</p>	<p>I am sure it will help, but I don't know enough about it</p> <p>Due to my very limited knowledge of hypnosis in the clinical setting I find it very difficult to comment on its use</p> <p>I am not sure what hypnosis exactly is; however I strongly support the use of traditional/alternative techniques to reduce pain in childbirth!</p> <p>I strongly agree with positive suggestions/ thoughts (with everything)</p>

CH midwives' comments	NCH midwives' comments
<p>My personal opinion is guided by my religious belief concerning meditation + hypnosis, but I believe if the woman wishes to use hypnosis in labour or to overcome phobias (e.g. needle phobia), then this is good for them</p>	<p>Mental state of the labouring woman is very powerful, anything to help for positive outcome is worth trying</p>
<p>I am not aware of evidence to support hypnosis for labour but feel that it is not a universal panacea + that woman can labour + give birth with hypnosis, epidurals or any other tools, they have the inherent ability to give birth in the majority of cases but hypnosis may help women with particular issues + may be a useful tool as water, massage, epidurals. etc. are for some women</p>	<p>I think that hypnosis can be a very useful tool for women during labour and have seen it used very effectively</p>
<p>(1) I don't know how someone could support a woman in labour without offering any positive suggestions; (2) As to whether hypnosis might be helpful in childbirth, I think it would be hard to measure as all are individuals + other influences contribute</p>	<p>Anything that can help a woman in labour, that is not "a drug" is a good thing</p>
<p>Training</p>	<p>None</p>
<p>Positive suggestion techniques were taught to me in my training</p>	
<p>I'd love to know more about hypnosis. How about an in-service on the topic?</p>	
<p>I feel it would be worthwhile for all midwives to learn, not just for student midwives</p>	
<p>As a seasoned midwife use positive suggestions frequently — some sort of formal/informal training would be fabulous!</p>	
<p>I think hypnotherapy should be an integral part of caring for a woman during her pregnancy and labour</p>	
<p>I believe it could be within the realm of midwifery — a skill that could be taught and utilised by the midwife</p>	

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A PRENATAL HYPNOTHERAPEUTIC PROGRAM TO ENHANCE POSTNATAL PSYCHOLOGICAL WELLBEING

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Hypnosis has extensively been applied for the relief of pain and discomfort during labour and delivery. Its role in addressing psychological processes during pregnancy and childbirth also recently gained some attention from clinicians and researchers. However, existing interventions do not address psychological aspects such as the transition to motherhood, postnatal adjustment, or psychological wellbeing. This article presents an evaluated prenatal hypnotherapeutic intervention focusing on preparing first-time mothers psychologically for the experience of childbirth and the early postpartum period. The program integrates principles from developmental psychology, positive psychology, and Ericksonian and ego-state hypnotherapy. It specifically focuses on activating and utilising inner resources that could contribute to helping the new mother cope with this life transition, as well as enhance her general psychological wellbeing after childbirth.

Hypnosis has been used for decades to assist women in coping with the pain of labour and delivery. Hammond (1990) compiled a comprehensive collection of suggestions and metaphors that can be applied in obstetrics and gynaecology. Several approaches to hypnotic childbirth preparation can be found in the literature, such as those suggested by Hilgard and Hilgard (1994), Leeb (1995), McCarthy (1998, 2001), Oster (1994), Oster and Sauer (2000) as well as Schauble, Werner, Rai, and Martin (1998). Some authors have also focused on the use of hypnosis to address anxiety related to medical procedures, stress,

fears or conflicts about childbirth, as well as negative perceptions and beliefs (e.g., Mairs, 1995; Mantle, 2000).

Regardless of the specific approach, it is generally accepted that the inclusion of hypnosis in preparation for childbirth can be beneficial to both mother and baby (e.g., Kroger, 1977; Oster and Sauer, 1997) and empirical evidence related to the effect of hypnosis for pain relief during labour has recently been reviewed (Cyna, McAuliffe, & Andrew, 2004). In most hypnotherapeutic childbirth preparation programs, however, even when the psychological experience of labour is acknowledged (e.g., Mehl-Madrona, 2004), the focus is often on birth outcomes such as reduced labour length or reduced birth complications. The psychological transition from pregnancy to motherhood, as well as factors related to psychological wellbeing during and after childbirth, are rarely addressed.

In view of the above, it could be argued that there is a need for a more holistic approach, enabling the client to have a comfortable and satisfying birth experience, but which will also prepare her for her new role and identity as a mother and facilitate general psychological wellbeing. In this article, an outline of a prenatal hypnotherapeutic program aimed at preparing first-time mothers psychologically for the experience of childbirth and the early postpartum period is presented. The effect of this program on postnatal maternal psychological wellbeing has been empirically evaluated, indicating an increase in psychological wellbeing at two weeks postpartum, and a decrease in depressive symptomatology specifically at 10 weeks postpartum (Guse, Wissing, & Hartman, *in press*).

The program is presented with reference to the aim, theoretical background, program outline and structure, as well as intended outcomes for the six sessions. Excerpts from the content of scripts implemented in sessions are presented.

AIM OF THE PROGRAM

The aim of the program is to prepare first-time mothers psychologically for the experience of childbirth and the early postpartum period. It specifically focuses on activating and utilising inner resources that could contribute to helping the new mother cope with this life transition, as well as enhancing her general psychological wellbeing after childbirth.

THEORETICAL RATIONALE

The development of the program was based on integrating principles from developmental psychology, positive psychology, Ericksonian approaches to hypnosis, as well as an ego-state approach to hypnosis.

From a *developmental perspective*, pregnancy can be seen as a major life event during which a woman typically experiences profound physiological, emotional, and interpersonal changes (Bergum, 1997; Deutsch, Ruble, Fleming, Brooks-Gunn, & Stangor, 1988; Zwelling, 2000). These changes are often viewed as part of the preparation for motherhood (Lederman, 1996). Being pregnant has been considered as contributing to the experience of an altered state of consciousness (Colman & Colman, 1991) and there seems to be a strong inward focus during this period (Zwelling, 2000) which may facilitate the utilisation of hypnosis during pregnancy.

When pregnancy finally culminates in childbirth, women have intense emotional experiences, making it an event of great psychological importance. It has been suggested that a positive experience of childbirth could contribute to feelings of mastery and satisfaction (Humenick, Schrock, & Libresco, 2000), and therefore indirectly to enhanced psychological wellbeing. Extensive literature on childbirth preparation exists, both within the field of nursing (e.g., Nichols & Humenick, 2000) and hypnosis (e.g., Hammond, 1990).

However, in most childbirth education classes the adjustment to pregnancy or parenthood is rarely addressed (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997) and attending classes has not been found to increase psychological wellbeing (Lumley & Brown, 1993). Still, early motherhood seems to be experienced by most new mothers as exhausting and difficult, since this is the period where the actual transition to motherhood occurs (Barclay et al., 1997). Most seem to feel ill-prepared for the demands of early motherhood (McVeigh, 1997). In view of the above, an intervention aimed at enhancing postnatal adjustment should therefore acknowledge developmental aspects related to childbearing, as well as address preparation for the actual childbirth experience.

In order to facilitate psychological wellbeing, the current program also incorporated principles from the domain of *positive psychology* in which the focus is, inter alia, on positive traits, experiences, and human strengths (Aspinwall & Staudinger, 2003; Keyes & Haidt, 2003; Lindley & Joseph, 2004; Peterson & Seligman, 2004; Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2002). In this program, pregnant women's inner resources and psychological strengths are utilised and mobilised within the context of the transition to motherhood.

Hypnosis, specifically Ericksonian and ego-state therapy approaches, is well suited to facilitate a positive childbirth experience and enhanced postnatal psychological wellbeing. The Ericksonian approach values an individual's inner

resources, which are thought to enable her to deal with her life circumstances (Gilligan, 1987; Zeig & Rennick, 1991). According to Walters and Havens (1994), this approach is also in concordance with the current paradigm shift towards wellness and wellbeing. Further, techniques from ego-state therapy, and more specifically ego-strengthening and the mobilising of inner resources, as developed by Phillips and Frederick (1995), as well as Frederick and McNeal (1999), are applicable to facilitate psychological wellbeing.

PROGRAM OUTLINE

The program consists of six sessions, each with a specific focus. However, the threads that are woven into all the sessions are utilising inner resources, seeding hope and optimism, maintaining health and wellbeing, and preparing for change and growth. The program may be more appropriately used for individual sessions, rather than group sessions. The sessions vary in length, ranging from 30 to 45 minutes. It is important to note that the program presented here was structured to facilitate empirical evaluation. In clinical practice, improvisation is encouraged to allow for individual tailoring for different clients.

At the beginning of each session, some time should be spent to address any concerns the client may have before commencing with the actual program content. The script for the specific session can then be delivered. After terminating trance, the client should have the opportunity to share her experiences of the session. This may provide valuable information on, for example, how the ego states were experienced. These specific images could be applied again in further sessions to reinforce ego-strengthening.

In presentation of the program content, only excerpts of the actual scripts are included since the actual program is of considerable length. The complete script is available from the corresponding author. Words in upper case are woven throughout the whole of the program as significant “markers” that could be heard by the unconscious mind (cf. Battino, 1999).

PROGRAM CONTENT

Session 1: Guiding Towards Self-Hypnosis and Commencing Ego-Strengthening

Objectives

- To invite the client to experience hypnosis as naturalistic trance;

- To guide the client to get in touch with some of her inner resources, referred to as “Inner Strength” (adapted from Frederick and McNeal, 1999);
- To assist the client in finding her own, personalised way of entering trance and finding her inner resources, and to utilise self-hypnosis (adapted from Hunter, 1994).

Expected Outcomes

After experiencing this session, the client should be able to apply self-hypnosis and should have become aware of a sense of Inner Strength as a potential inner resource. She will also feel more prepared for further hypnotherapeutic work.

Excerpt

“I wonder whether you would like to make yourself COMFORTABLE and PREPARE yourself for a journey inside yourself ... a journey that you could perhaps find INTERESTING or ENLIGHTENING, or maybe even COMFORTING ... and perhaps you can realise ... that there are MANY WAYS ... to PREPARE yourself for a journey ... LOOKING FORWARD to the actual experience ... picturing yourself on the journey, WORKING OUT the most interesting and REWARDING way to get to your destination ... and right now you can ... simply allow yourself to become absorbed in this experience ... absorbed in yourself ... Maybe focus on your breathing ... and notice that with every breath you take, you are taking in something and letting out something ... such a NATURAL CYCLE ... of taking in and letting go. That’s right. Taking in peace, letting out tension ... taking in courage ... letting out worries ... that’s right ... ”

Comment

In the excerpt, Ericksonian principles such as seeding, interspersal as well as pacing and leading are utilised to induce a naturalistic trance. The journey metaphor is included to facilitate the idea of a journey to motherhood.

Session 2: Further Facilitation of Inner Resources by Means of Ego-Strengthening

Objectives

- To enhance the client's experience of her inner resources by means of activating ego-states referred to as "Inner Advisor" and "Inner Love" (adapted from Frederick and McNeal, 1999);
- Establishing the metaphor of an "Inner Team" as inner resource to draw upon during labour, delivery, and the postpartum phase;
- Continuous seeding of the possibility of growth and maintenance of well-being.

Expected Outcomes

The client will have experienced the additional resources of the Inner Advisor and Inner Love; she will own the metaphor of an Inner Team to draw upon during labour, if so wished; and she will be aware of the possibility of growth and psychological wellbeing.

Excerpt

"As you consider what your Inner Advisor has told you, you might want to imagine what the rest of your pregnancy, your labour, the birth of your baby, and your new role as a mother would be like if you took the advice and put it into action ... perhaps you are surprised at how MEANINGFUL it could be to make TRANSITIONS ... perhaps your advisor assures you about your INNER WELLBEING ... that has existed for most of your life ... maybe you need to clarify a few thoughts with your advisor ... take your time to LEARN AND TO GROW ... you have all the time you need ... and when this experience of meeting you Inner Advisor is completed for you, you could just indicate by a nod of the head. Good ... and when it seems right ... you might want to thank your advisor for meeting with you ... and you can ask your advisor what the easiest way could be to get in touch with it again in the future ... realise that you can meet your advisor whenever you feel the need ... now and in the future ... and isn't it wonderful and COMFORTING to know that you know more than you think you know ... there is so much WISDOM AND KNOWLEDGE inside yourself that you perhaps haven't realised before ... "

Comment

Frederick and McNeal (1999) conceptualised the Inner Advisor as a source of comfort and support, which is also compassionate, with the client's best interests in mind. By incorporating this technique, it is expected that access to such a guiding and wise part could contribute to the woman's sense of self-efficacy and coping during her life transition. In this excerpt, the Ericksonian principle of seeding is also utilised.

Session 3: Facilitating the Experience of Labour and Delivery

Objective

The objective of this session is preparation for the experience of labour and delivery, by applying various hypnotic phenomena and suggestions adapted from the scripts by Hunter (1994), McCarthy (1998, 2001), Peterson (1993), and Schauble et al. (1998).

Expected Outcomes

In this session, the expectant mother will experience a "mental rehearsal" of the actual labour and delivery. Hereafter, she will know more about what to expect and be more aware of her inner resources that could contribute to her coping with labour and delivery.

Excerpt 1

" ... you can imagine that a contraction is coming ... like a wave building up ... until it finally crashes onto the shore ... and recedes again ... and you can choose to experience each wave ... or to take yourself away to another place, another experience ... just the way you did when practising your own hypnosis ... you might want to become absorbed in your own internal experience every time you feel a contraction ... coming out of the experience after it is finished ... or you might want to remain comfortably inside all the time, relaxing more and more every time you feel a contraction ... it's up to you ... and it is amazing to think about just how easily you CAN MAKE A CHOICE during your labour ... after every contraction you can allow yourself plenty of time to rest ... STRENGTHENING yourself ... PREPARING yourself to continue your journey ... knowing that you have within you an Inner Team to assist you ... your Inner Strength, Inner Advisor and your Inner Love ... and we all know that teamwork makes any work so much LIGHTER and more BEARABLE, don't we?"

Comment

In this excerpt, McCarthy's (1998) metaphor of contractions as waves is incorporated. There is also seeding of the idea of choice and control, and utilisation of the concept of an Inner Team, consisting of Inner Strength, Inner Advisor and Inner Love, as conceptualised by Frederick and McNeal (1999).

Excerpt 2

“That’s right ... and you are there now ... now things can change rapidly ... because the aim of each contraction is to push ... push really strongly ... guiding your baby ... through the birth channel ... and now you can play a different part in your baby’s birth ... you and your Inner Team can work with the medical team to channel your baby into the world ... the world of warmth and love ... so that it can SLIDE EASILY AND COMFORTABLY INTO THE WORLD ... Now ... with every contraction ... you can go deep inside yourself ... adding your energy and strength to the strength of every contraction ... and you can enjoy being such a part of your baby’s journey ... as your baby glides further and further down ... you can go deep inside yourself ... being part of the power and strength ... just as you are a part of your Inner Team ... and as every contraction fades away ... you can let go of the memory of that contraction ... and use the time to really relax ... collecting your energy ... preparing yourself for the next contraction ... and you may be surprised to find that the periods between your contractions seem long and refreshing ... while each contraction can pass like a flash, utilising all the energy you and your body ... and your Inner Team ... have combined. When the next contraction arrives ... you can again move deeper inside yourself, be part of the strength, guiding your baby in to the world ... like when you push a child gently down a slide ... ”

Comment

This part of the script was adapted from existing scripts by Hunter (1994) and Peterson (1993). There is an affirmation of the mother’s active participation in stage two labour, and ease during delivery is seeded. Hypnotic phenomena such as amnesia and time distortion are also suggested.

Session 4: Facilitating Bonding and Development of Motherhood Identity

Objectives

- To facilitate bonding and attachment while the baby is in the womb;
- To facilitate the development of motherhood identity by means of ego-state therapy techniques.

Expected Outcomes

The client will experience a sense of having a bond with her baby, which may promote postnatal attachment. The expectant mother will experience a sense of confidence that she has the necessary competencies to fulfil her role as a mother.

Excerpt

“And there is something else that you might find very interesting today ... something that might be meaningful to you in a very DEEP AND SPECIAL way ... something you might find valuable now ... after your baby’s birth and for many years to come ... While you continue to relax and remain comfortably in your own internal experience, perhaps you would be interested in meeting another possible part inside yourself ... a part that could still be developing ... a part that could perhaps be called ... the evolving mother ... or the budding mother ... that part that enables you to fulfil the role of a mother ... to nurture, to care for someone ... you can just focus deeply inside yourself ... and when you find that part inside yourself ... you can just indicate by a nod of the head. Good ... it could actually be fascinating to realise that this mother-part could have been developing since the moment you found out that you were pregnant ... you have started to watch what you eat ... looking after your health ... started to build your life around your baby’s birth ... that’s right ... you have been practising hard to become a mother ... both consciously ... and unconsciously ... perhaps your internal resources ... your Inner Team ... has assisted without your realising it ... and it is good to know that you have SO MUCH KNOWLEDGE AND STRENGTH INSIDE to assist you in being a mother, isn’t it?”

Comment

This excerpt illustrates how ego-state therapy techniques could be used to facilitate the gradual development of motherhood identity, as well as general ego-strengthening.

Session 5: Facilitating Postpartum Wellbeing

Objectives

- To prepare the mother for the demands of the postpartum period;
- To facilitate the idea of general psychological wellbeing in the postpartum period.

Expected Outcomes

The client will develop a positive expectancy of the postpartum period, an enhanced sense of self-efficacy, and will anticipate personal growth during early motherhood.

Excerpt

“... allowing yourself to look into the future makes you feel COMFORTABLE AND OPTIMISTIC about your capabilities in fulfilling the role of a mother. You might even be surprised to realise that you have GAINED A NEW DIMENSION of being ... which amplifies all your other dimensions ... a wife ... an individual ... a total woman ... almost like discovering the many different facets of a brilliant diamond ... all of which contribute to the uniqueness of the diamond ... and maybe you know that diamonds are all unique ... all different and special ... developing over millions of years ... such a special gem ... and only through lots of effort and hard work does its true beauty become visible ... and perhaps you can later bring with you ... your own gem ... that you can discover deep inside yourself ... And I wonder whether you are aware of a sense of HEALTH and STRENGTH inside ... aware of your INNER RESOURCEFULNESS ... your ability to experience this transformation in a positive way ... and you can choose to store all these positive experiences and feelings ... the knowledge of your INNER HEALTH and WELLBEING ... now and later ... it can truly become a part of yourself ... And when you come back to the present, you can bring with you a special gift ... you can bring with you all the positive images, sensations and feelings ... back from the future ... to help guide you on your journey now and later

... perhaps you can bring with you all the gems that have been waiting to be discovered ... and you can also realise ... that just as your Inner Team has been working together through your pregnancy and delivery ... they are part of you ... part of a whole ... part of your INNER WELLBEING ... they will always be there to guide you through your journey of life ... ”

Comment

Torem's (1992) age progression technique is utilised here to aid ego-strengthening and to seed the idea of growth and a positive expectancy of the postnatal period. The concept of an inner team is again included as a possible internal resource.

Session 6: Addressing Individual Needs

Objectives

- To meet individual needs that could possibly arise during the course of the program;
- To reinforce aspects of the program as requested by the client.

Expected Outcomes

Specific needs of clients will be met to allow for tailoring of suggestions.

Comment

This session makes it possible to address individual needs, therefore no script has been developed. Clinical experience indicated that many women request a repetition of Session 3 (preparation for labour). In some cases women were advised to consider having a caesarean section although they first considered natural childbirth. In these instances, preparation for the procedure was included in the final session.

CONCLUSION

As Cyna et al. (2004) have pointed out, it does seem that antenatal preparation for childbirth leads to decreased analgesia requirements. The current program may expand the application of hypnosis during pregnancy by also focusing on the psychological transition to motherhood and facilitating psychological wellbeing. It is hoped that this article inspires both clinicians and researchers

to widen the application of hypnosis to also include positive aspects of psychological functioning.

The current program has empirically been found to have a significant effect on a group of Caucasian women in South Africa (Guse et al., in press). It needs to be evaluated further in other groups and in various cultural contexts. It can also be adapted to include other strengths and positive traits identified from a positive psychology perspective.

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ASSESSING ALLEGATIONS OF SEXUAL ASSAULT DURING HYPNOSIS AND RELATED PROCEDURES

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There are a number of reasons why those professionally involved with hypnosis may be asked by people outside the field for their knowledge and advice. One occasion is when the criminal and civil justice systems require expert assistance in legal cases in which hypnosis, or a related procedure, has been or may have been involved. The author of this paper has been asked for his opinion on 14 cases in which it has been alleged that the defendant sexually assaulted the complainant while he was undertaking hypnosis with him or her. In this article, the author discusses some of the issues involved in assessing, as an expert witness, such allegations, with particular reference to the relationship of hypnosis and will. In the author's opinion, to address the issue of the passivity and compliance that many complainants exhibit in these cases requires a detailed consideration of social psychological factors inherent in the doctor–patient or therapist–client relationship, rather than factors specific to hypnosis. However, there are a number of aspects of the context and manner in which hypnosis may be conducted that could render the patient or client more passive and compliant and therefore possibly more vulnerable to sexual assault.

As with many fields of scientific enquiry and activity, professionals who study hypnosis academically, or apply it as a clinical or therapeutic procedure, are from time to time called upon to provide those outside of the field with the benefit of their knowledge and expertise. Because of the public fascination with hypnosis, this not uncommonly happens when producers of television or radio programs are planning documentaries on hypnosis and its applications, and similarly when journalists write features in newspapers and magazines, often when hypnosis has been in the headlines. Expert opinion is also sometimes requested in the legal domain, when cases in which hypnosis or similar procedures have been involved are brought before the courts.

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HYPNOSIS AND THE COURTS

Hypnosis has probably been most often associated with the courts in its use in the interrogation of witnesses to crimes, in an attempt to assist recall. This application has proved to be highly controversial (see, e.g., Wagstaff, 1999) and since the late 1980s the Home Office has adopted an unfavourable attitude to this practice (Home Office, 1989). In several states of the USA, hypnotic testimony has been banned as admissible evidence (Perry, Orne, London, & Orne, 1996), and in Australia forensic hypnosis researchers (Sheehan, 1988) have warned practitioners against the use of hypnosis for the purpose of recalling information for use in legal cases.

Since the 1990s, the courts in a number of countries have called upon experts in hypnosis for advice on alleged memories of criminal assault, notably sexual molestation and rape, that have been elicited during hypnosis. Sometimes these “memories” have arisen during psychotherapy and are usually reports of childhood experiences by adult clients. The role of the expert witness in such cases has normally been to advise the lawyers on the soundness of evidence in the form of such “memories.”

From the early history of hypnosis onwards, there has been interest in whether a person, while hypnotised, can be induced to commit a crime that he or she would otherwise be unwilling to undertake (see Laurence & Perry, 1988). It appears that instances in which the defence makes this claim are very rare. (I have provided written testimony in two such cases; in both of these, the evidence that hypnosis or, for that matter, any “mind altering” procedure was used on the defendant was virtually non-existent.)

The majority of criminal cases for which the present author has provided expert opinion (ranging from verbal advice given to the police to lengthy reports provided for the court) have been those in which the complainant alleges that he or she has been sexually assaulted during a session of hypnosis, relaxation, guided fantasy, and so on. I shall shortly return to a consideration of such cases.

So far, the cases to which I have been referring are those normally dealt with by the criminal courts. As in most countries, we also have civil courts in the UK. Claimants in civil cases in which the author has been involved have sought financial compensation for psychological injury due to the negligence of therapists who have used hypnosis or similar procedures (see Heap, 1996) and of stage hypnotists (Heap, 2000a). In one such case, I provided a written statement for a case involving stage hypnosis that was dealt with by the

Coroner's Court (1995b). I have reviewed elsewhere the alleged dangers of stage hypnosis and the psychological assessment of claims involving this (Heap, 2000b).

ALLEGATIONS OF SEXUAL ASSAULT DURING HYPNOSIS AND RELATED PROCEDURES

Published Accounts

Laurence and Perry (1988) provide an authoritative review of historical cases in which hypnotists have been charged with indecently assaulting their patients or subjects. They also summarise some accounts from the 1970s (Conn, 1972; Kline, 1972; Perry, 1979). Some published cases have also been critically reviewed by Gibson (1991).

A case worth mentioning here is that described by John Hartland (1974), a British psychiatrist well known in the field of hypnosis. The defendant was an obstetrician who was consulted by a female patient in his private clinic at home. During the consultation, he conducted a manual antenatal examination of her womb. In order to facilitate this he used hypnosis to help the patient, who was very apprehensive, to relax. No chaperone was present. According to the defendant, nothing untoward occurred, but later that evening, as he was leaving his house, he was accosted by the patient and her husband and accused of indecently assaulting her by massaging her vagina and forcing her to fondle his penis. He was later charged with the assault. There were two expert witnesses for the defence, a consultant obstetrician who used hypnosis in his work and Hartland. Both experts insisted that hypnosis would not allow the doctor to force the patient to do anything to which she strongly objected. The judge had some difficulty understanding this, as one of the methods used by the defendant was arm immobility, to which the patient had responded. However, the defendant was acquitted by a majority verdict.

Judd, Burrows, and Bartholemew (1986) describe a case of indecent assault with intent to rape (*Regina v. Davies*; County Court of Melbourne). The defendant, who was convicted, was a lay therapist who was treating the female complainant for weight loss. The complainant averred that she was unable to resist the hypnotist's sexual advances because she was "so helpless — so hypnotised." However, a knock on the door terminated the proceedings, whereupon the complainant jumped off the couch, pulled her dress back down and left the room. This case has been critically examined by Gibson (1991).

Jonathan Venn, an American psychologist, summarises the cases of two young male soldiers who alleged that an officer made homosexual advances to them after he had performed hypnosis on them (Venn, 1988). Discrepancies in the accounts of what happened and the complainants' heavy consumption of alcohol make it difficult to conclude what role, if any, could have been played by hypnosis or the hypnotist.

Hoëncamp, a Dutch psychiatrist, has documented cases of assault on nine female patients by a lay hypnotist from 1979 to 1982 (Hoëncamp, 1989). Publicity arising from an accusation by one of the patients in 1982 brought forth numerous accusations from other women. Typically, the defendant would try to persuade the women that their problems were related to their sexuality, and during hypnosis he would touch and massage their bodies in an increasingly intimate and sexual manner. Some of the women resisted this, but some felt unable to, even though they did not wish the therapist to continue, and despite this, some returned for further sessions. The therapist allegedly had intercourse with one of the women on two occasions.

The case of *Regina v. Nelson* (Bristol Crown Court, 1991) was the subject of some discussion and disagreement amongst the expert witnesses involved (see *Contemporary Hypnosis*, Vol. 9, 1992). The defendant was convicted of indecent assaults on minors whom he videotaped, while they underwent hypnosis for problems such as nail biting. One of the expert witnesses, Dr H. Gibson (Gibson, 1992), reported that the judge appeared to accept the idea that one of the girls whom Nelson assaulted was not aware of what he was doing, was totally amnesic afterwards, and was genuinely horrified to see a video Nelson had made of the proceedings. However, Gibson questions these assumptions.

In the case of *Regina v. Pearson* (Sheffield Crown Court, 1994; see Heap, 1995a), the defendant was a lay hypnotist who visited a female client at her home to help her stop smoking. During the hypnosis session the complainant was allegedly intimately fondled by Pearson while lying on a bed. She also, for a time, had her hand placed around his exposed penis. She was fully aware of what was happening, felt that she did not want it to happen, and yet felt "paralysed" and completely unable to resist. The defendant was convicted and given a prison sentence of nine months.

In Heap (in preparation), I describe the case of *Regina v. Darwish* (Manchester Crown Court, 1999). The defendant, a gynaecologist and obstetrician, was indicted on over a dozen charges of indecent assault and one of rape over the period from 1980 to 1991. The complainants were 13 of his

ex-patients. His case came to trial in 1999, several of the complainants having come forward years after the alleged events, to have their statements compiled by the police, when news of one of the accusations against the defendant first appeared in the local press.

Most of the charges were made by patients who complained that while they were lying on the examination table, the defendant used hypnosis on them by massaging their bodies; he would stroke their forehead, arms, abdomen and legs and repeat suggestions of relaxation, heaviness and so on. Sometimes he would begin the procedure with an eye-fixation procedure. The complainants alleged that, while he was stroking them, his hands would wander to their breasts and between their thighs in an inappropriate manner. Most of the women said that the defendant actually told them he was using hypnosis, but in his statements he denied this and said that he only used the term "relaxation." He also denied using any massage techniques. In all cases, he was seeing the patients in a private clinic and there was no chaperone present.

During the defendant's relaxation procedures, most of the women reported remaining tense, vigilant, and very confused about what was happening, but were somehow unable to protest or halt the proceedings. Most did not describe themselves as "hypnotised." Typically, they could make little sense of what the defendant was doing and felt that there was something wrong; at the same time, they rationalised that he was a doctor, at the top of his profession, and they presumed "he knew best."

Some of the complainants informed their husbands or members of their family immediately afterwards about what had happened, but others did not disclose what had allegedly happened until years later. One complainant, who was allegedly assaulted by the defendant in 1984, only told someone when news about his being charged appeared in the media in the late 1990s. As with other cases in which I have been involved or which have been reported in the literature (e.g., Hoëncamp, 1989), some women, including a complainant who alleged oral sex and rape, apparently returned for one or more appointments following the alleged assaults.

The defendant was found guilty on eight counts of indecent assault. On the charge of rape, he was pronounced not guilty. He received a prison sentence of six years.

Finally, Hawkins (1993) has provided a thoughtful analysis of some of the issues involved in the analysis of intimacy between clients and therapists during hypnosis. This is broadly in agreement with that presented in the present paper.

The Role of the Expert Witness

It seems that, in the UK at least, the courts require the expert witness in these cases to confine his or her attention to the documentary evidence (the complainant's and defendant's statements, transcripts of police interviews, medical records, other witness statements, and so on) without interviewing either of the principal parties involved. The role of the expert witness, in such cases, largely entails examining the claimant's allegations and providing advice to the court as to their credibility. Of particular concern are apparent anomalies that are present in such cases — most notably the failure of the complainant, despite the absence of any physical threat by the hypnotist, to call a halt to the proceedings, or at least to take protective action. Although any intimacy by the defendant is inexcusable from a moral, ethical, and professional point of view, from a legal point of view the court will be concerned about whether the complainant was able to give consent.

Other common anomalies are the complainants' not challenging the therapist once hypnosis is concluded, not disclosing immediately to others what the hypnotist allegedly did, and in some cases, returning for further appointments following the alleged assault. Specifically, the expert will be asked his or her opinion as to whether, if the complainant's allegations are authentic, hypnosis can account for these anomalies. (I acknowledge here that readers who are experienced in working with people who have been sexually assaulted may not regard much that is in the previous case vignettes as anomalous, but it is important to make clear to the court the reasons why this is so.)

Another concern that is commonly raised by lawyers is the reliability of the complainants' memories of events that took place during hypnosis. First, very occasionally, a complainant claims temporary or permanent amnesia for details of the alleged assault. Second, there is the question frequently raised by the defence as to whether the complainant could have fantasised the assault and then accepted it as authentic: in other words, the assault is a false memory.

As always, the expert's role is to assist the court and this requires objectivity and impartiality at all times, whether he or she is instructed by the defence or the prosecution. When presenting evidence in written or oral form, it is important to support, whenever possible, assertions about hypnosis with reference to the research literature.

Some Considerations in Assessing Allegations of Sexual Assault during Hypnosis

For the purposes of the present paper, I shall confine this discussion to the question raised by both the defence and the prosecution of whether hypnosis has the property to render a person obedient to the will of the hypnotist. Clearly, other issues are involved and I present a fuller analysis of these in Heap (in preparation).

Did the Defendant Use Hypnosis and Were the Complainants Hypnotised? These are two of the questions that lawyers may ask the expert witness to address. It is not uncommon for defendants to insist that they were not using hypnosis, but rather “progressive relaxation,” “guided imagery” and so on. My usual advice is that the court need not be unduly concerned about how we label the procedures: This is unlikely to affect the answers to the questions posed. If pushed, I explain that for a procedure to be labelled “hypnotic,” it must exploit a person’s capacity to respond to hypnotic suggestion. That is, it should consist of verbal statements and imagery that are directly intended to affect the experiences, thoughts, perceptions, and behaviour of the subject (Heap et al., 2001). Where the intended changes are limited to physical and mental relaxation, as with most hypnotic induction and deepening techniques, then nothing productive is going to emerge from time and effort spent debating whether or not the defendant was using hypnosis as opposed to any other procedure.

The same considerations apply to the question of whether a complainant was “hypnotised.” Ask any number of experts what criteria one should use to define a person as “hypnotised” and you will hear many different answers, one of them being that it is not a meaningful question. I prefer to think of hypnosis as an activity in which both the hypnotist and the subject are engaged and I rephrase the question thus: “Did the complainant respond in the manner intended by the suggestions?” Most of the complainants in, for example, the case of *Regina v. Darwish*, summarised earlier, described themselves as tense and very alert to what was going on around them; in other words, they were very *unresponsive* to the defendant’s suggestions.

This approach to the question is at odds with that taken by Hartland (1974; see earlier) in his account of a similar case. The complainant in that case maintained that she was not hypnotised at the time of the alleged assault, but only “acted out of fear.” In his paper, Hartland states that after the defendant gave his evidence, “it became increasingly obvious that the Defence could only

succeed, if it could convince the Court that [the complainant], despite her denials, was actually in a state of hypnosis at the time of the alleged incidents.” Both defence experts averred that it was likely that the patient had been “in a trance” at the time and therefore may have hallucinated or fantasised the alleged incidents.

Why Are Complainants so Passive and Compliant? This is obviously a major question in many cases: The fact that the complainant avers that, although she wanted the defendant to stop, she did not resist the alleged assault, and indeed in some cases actively participated in sexual activity, may undermine the credibility of her testimony. Can hypnosis account for this anomaly, if her testimony is to be considered as accurate? Does hypnosis have the property to render people unable to protect themselves against the hypnotist’s unwelcome sexual advances, and obedient to his suggestions to engage with him in sexual activity?

From a theoretical perspective alone, it is difficult to cite, with due confidence, that the elicitation of hyper-obedience is a property of hypnosis, even in highly hypnotisable people. There is also little evidence for this in the research literature. In laboratory studies, a significant proportion of participants can be persuaded to commit repugnant, antisocial, and seemingly dangerous acts (e.g., Milgram, 1974) and in experiments that have compared hypnotic subjects with controls, the evidence does not indicate any major differences (Coe, Kobayashi, & Moward, 1972; Gibson, 1991; Levitt, Aronoff, Morgan, Overley, & Parrish, 1975; O’Brian & Rabuck, 1976; Orne & Evans, 1965). Hence, before one attributes a subject’s apparent passivity and compliance to hypnosis, one must first ask whether he or she would have behaved, in the same way in the same context, in the absence of hypnosis.

I consider that the available evidence indicates that in the situations in which hypnosis is undertaken (scientific experiment, treatment, stage act, etc.), the coercive powers of the hypnotist are not the result of any property of hypnosis per se, but those of the context itself. In all these situations, the coercive influences are strong and in each case people may be persuaded to perform in extreme ways which normally they would refuse, and which they may regret later. That is, a hypnotist may be in a position to exert coercive power over his or her subject: first, because of the demands and expectations of the context in which hypnosis is being carried out; second, because the hypnotist (as experimenter, therapist, entertainer, etc.) is usually in a position of authority or dominance with respect to the person being hypnotised and

this itself endows him or her with significant power to invoke obedience in the subject or patient; and third, because the subject or patient may trust the hypnotist to the extent that he or she interprets any apparently inappropriate demands as safe and legitimate.

Passivity and Compliance in the Context of Clinical Hypnosis

Although diminished resistance to coercion may not be an effect of hypnosis per se, it is possible that there are particular aspects of the manner in which hypnosis is conducted that may reasonably be considered to inhibit a person's ability to challenge or resist what would otherwise be unacceptable behaviour by the clinician.

First, the hypnotic subject is usually seated or sometimes lying down, with her eyes closed. Second, the hypnotic context is an unusual one; by agreement, the therapist tends to direct what the patient does and experiences and the patient's task is to go along with this. The patient may also entertain the common expectation that, during hypnosis, she is indeed under the control of the hypnotist and will not be able to exercise her own will. It may be that this expectation itself has some inhibitory effect upon the patient's ability to resist unwelcome advances by the hypnotist. This possibility was given serious consideration by Perry in the case of *Regina v. Palmer* (Supreme Court, New South Wales, 1976: see Perry, 1979; and Laurence & Perry, 1988, pp. 311–318).

Another very important consideration is that the patient often has an unclear idea of what behaviour, on the hypnotist's part, is legitimate or otherwise. This especially applies to the issue of physical contact. There may be confusion in the mind of the patient as to where the boundaries lie between an authentic hypnotic procedure and physical intimacy on the hypnotist's part. Some hypnotists use massage techniques or stroking and, as in the cases mentioned earlier, occasionally hypnosis is used to facilitate a medical or dental procedure that requires direct physical contact between the hypnotist and the patient.

The above processes may accentuate another aspect of how patients experience uninvited intimacy by a doctor or therapist. Having implicitly placed their trust in the practitioner and taken for granted that his behaviour, at all times, will be consistent with his professional undertakings, many patients are understandably caught unprepared when his conduct departs from this. It is as though they lack the repertoire of responses to deal appropriately with the unexpected circumstances that have arisen. (What am I supposed to do now?) My impression from complainants' accounts is that this unpreparedness is compounded by their unfamiliarity with the procedures used by therapist.

A further factor related to the above, and that is relevant to many cases of alleged indecent assault, is what is sometimes called the “foot-in-the-door” effect or “assault by stealth.” (This is akin to victim grooming by sexual offenders.) By this process, the therapist may gradually interact in a more intimate manner with the patient, with his behaviour being legitimised as “part of the treatment.” This legitimising may be done explicitly; for example, some therapists have persuaded their patient to accept kisses, embraces and fondling, having explained to her that this will help her to let go of her sexual anxieties and inhibitions.

Even without any such explicit attempts by the hypnotist to legitimise his intimacy, the hypnotic context itself may render the patient or client vulnerable to the foot-in-the-door effect. A hypnotic induction itself can have quite intimate undertones, as in the simple case of a hypnotist’s administering suggestions of progressive relaxation in a gentle, soft tone of voice using expressions such as “warm, heavy and relaxed.” The patient may accept as entirely legitimate the hypnotist’s touching or stroking parts of her body. Having given licence to the hypnotist to proceed thus far, it may become more difficult for her to disengage when the hypnotist’s attentions become more blatantly sexual.

Why Do Many Complainants Wait so Long to Disclose? Occasionally, a lawyer will enquire as to whether post-hypnotic suggestion could operate to inhibit disclosure. I have elsewhere given detailed consideration to the possible involvement of post-hypnotic suggestion in both civil and criminal cases (Heap, 2000a, 2000b; see also Heap, in preparation). Briefly, although post-hypnotic suggestion may be experienced by the subject as having a compulsive quality, it involves cognitive effort on his or her part (Barnier & McConkey, 1996, 1998, 2001) and may be overridden by his or her volition if such is demanded by the situation. Importantly too, the influence of the suggestion is determined by the explicit and implicit demands of the context; that is, when those demands are perceived as no longer operative (or, in the present case, legitimate), the subject stops responding (Fisher, 1954; Spanos, Menary, Brett, Cross, & Ahmed, 1987; St Jean, 1978).

It is therefore most unlikely that inhibition of disclosure can be effected by simple post-hypnotic suggestion. Indeed, complete failure to disclose by victims of abuse, or disclosure only years after the incidents took place, is not uncommon amongst victims of sexual abuse generally for reasons we need not discuss here (see Heap, in preparation).

Why Do Some Complainants Return for One or More Appointments? Occasionally a lawyer will ask whether a complainant may have been compelled to return by the defendant's use of hypnosis. The obvious mechanism that suggests itself is again post-hypnotic suggestion. For reasons given above, I do not consider that it is at all likely that post-hypnotic suggestion can provide the explanation for why some complainants return to a therapist or doctor who has abused them.

Where the assault has been limited to unwelcome intimate fondling, then the processes, that I have already discussed, that foster passivity and obedience may be sufficient to explain further attendance. One possible factor is the personality and emotional vulnerabilities of the complainant: It is reasonable to speculate that an unassertive, compliant person with low self-confidence may be more likely to return than someone with the opposite characteristics.

However, repeated attendance in such instances may arise when the complainant develops a strong transference on the therapist, characterised by a high level of emotional dependency. There is an impression that transference may be intensified in therapy in which hypnosis is used (Orne, quoted in Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1989). For further discussion of this possibility, the reader is referred to Heap (in preparation).

CONCLUSIONS

From time to time in the UK, and I imagine elsewhere, the media carry stories about doctors, other health care professionals, psychotherapists, lay practitioners and so on, who have been charged or convicted with indecent assaults on their patients and clients and even rape. At the time of writing, UK journalists have recently finished digesting a report by a Committee of Enquiry set up by the Department of Health that investigated allegations of professional misconduct against two consultant psychiatrists from the same hospital. The report (Department of Health, 2005) states that two doctors indecently assaulted or raped many female patients. Accounts by these victims reveal how vulnerable, frightened, and helpless they felt, yet many continued to attend for treatment. Many were afraid to complain lest they would not be believed. In this respect they were realistic: Those complaints that *were* made to the hospital and health authority "fell on deaf ears," in the words of the report.

The two doctors did not require hypnosis to render their victims amenable to their sexual attentions: Their perceived authority, the natural submissiveness and compliance of their patients, their patients' vulnerabilities, and so on, not

to mention the unwillingness of junior staff and managers to question the all-powerful consultant, were sufficient to allow them a free reign over many years. This was the sober verdict of the report, echoed in typically more robust fashion by the press. Yet in the previously mentioned case of Regina v. Darwish (Heap, in preparation), although the complainants' subjective accounts were very similar to those of the victims of these two doctors, the newspapers (e.g., *Daily Mail*, 10 October 2001) made great play of how, through the power of hypnosis, Darwish had been able to turn his patients into "zombies" and have his evil way with them.

Surveys of the incidence of doctor–patient or client–therapist intimacy (e.g., Schoener et al., 1989; Jehu, 1994) have revealed that these are not rare events. In order to understand why patients and clients often passively accept the sexual attentions of the practitioner, and even actively participate, it is necessary to understand the relevant social psychological processes, as well as the emotional dynamics of the doctor–patient or therapist–client relationship. In my experience, the same is true of allegations of sexual intimacy when hypnosis or a similar procedure has been involved. In such cases, it is rarely necessary to invoke some special property of hypnosis in order to account for the behaviour and experience of the complainant. Nevertheless it is important to be alert to the more general aspects of the hypnotic context and to the attitudes and expectations of complainants concerning hypnosis, when considering their vulnerability to sexual exploitation by the practitioner.

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HYPNOSIS AND PHANTOM LIMB PAIN

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Treating phantom limb pain is a difficult task, as its pathophysiology and aetiology are not yet well understood (Jensen & Rasmussen, 1994). Patients with phantom limb pain not only suffer enormously, but they are also mystified and frustrated by their experience of pain in a limb that is no longer there. Among many treatments available, hypnosis could be promising, since it is well known to be effective in the treatment of pain (Hawkins, 200; Montgomery, DuHamel, & Redd, 2001). The following case study addresses the application and effectiveness of hypnosis in the treatment of phantom limb pain.

MH was referred by his general practitioner for chronic pain management. A psychological assessment was subsequently completed as an integral part of the multidisciplinary pain assessment at the pain management centre.

PRESENTING PROBLEMS

MH presented with persistent unpredictable periodic neuropathic phantom limb pain from his left amputated leg. MH reported that there was no stump pain or pre-amputation pain, defined as pain occurring prior to amputation and continuing after amputation (Jensen & Rasmussen, 1994). MH described his pain as feeling like pins and needles throughout the left leg when it was mild, and sharp like a saw cutting into his left toes and a drill pushing into his left heel, when it was severe. The severe pain usually started in the evening and lasted till midnight. This pain was most distressing to MH. The mild pain had been present throughout the day without troubling him much.

The onset of the phantom limb pain was about seven years ago, two years after a below-knee amputation that had resulted following a fall from a ladder. MH had been managing the pain by himself for a few years with

some success. However, over the last two years the pain had worsened and caused enormous distress. Upon assessment, he was unable to identify any reason for such deterioration. Moreover, the results of the West Haven-Yale Multidimensional Pain Inventory (WHYMPI) (Kerns, Turk, & Rudy, 1985) and SF36v2 (Ware, Kosinski, Turner-Bowker, & Gandek, 2002) indicated a high affective (emotional) component of his phantom limb pain.

Clinical Presentation (Psychological, Social, Medical, Psychiatric) and Personal History

MH presented as a 74-year-old man of medium build and was well-groomed. MH had worked as a tailor and had retired fourteen years previously. He had been married twice and divorced once, and had three sons who were living in another state. His second wife had committed suicide about 20 years previously, while they were still married. He was currently living with a female friend who was a 62-year-old chronic pain sufferer and a friend of his mother. MH denied any romantic relationship with her. MH had maintained regular contact with his sons. He had been interested in physical training for fitness and unfortunately ceased such interests after the amputation. MH had been working on an invention relating to physical training equipment.

MH reported that he and his housemate had been harassed by their neighbours for the past two years. MH described a number of incidents caused by their neighbours; for instance, fireballs being thrown into his house that broke glasses and caused small fire damage, his front yard being poisoned, rocks being thrown onto his house roof, and his gardening tools being stolen. He felt that he has not had appropriate protection or assistance from the police. It appeared that he has been distressed by all these neighbourhood harassments and worried about his own safety. Interestingly, the onset of all neighbourhood disputes and distresses coincided with the onset of MH's pain deterioration.

Upon the initial assessment, MH reported that he has not felt depressed, but slightly helpless in managing his pain. No anxiety was reported. These responses were consistent with the results of the Depression Anxiety Stress Scale²¹ (DASS21) (Lovibond & Lovibond, 1995) which showed that MH's scores fell within the normal range across all scales. Moreover, MH reported no post-traumatic stress from the fall that caused the amputation. He accepted the amputation calmly and had no unresolved issues regarding it. MH reported no psychiatric history or past trauma and did not believe that he had any unresolved grief over his second wife's suicide.

MH reported suffering from medical conditions including hypertension, angioplasty, and high cholesterol and had been taking Tramal, Panadine Fort and Temaze.

MH's coping strategies for chronic pain included self-talk, medication, eating ice-cream, and massage. It appeared that MH was psychologically oriented; for instance, he believed that his mind could control his body, so application of psychological techniques for pain control was considered by him to be highly desirable.

The assessment of his pain cognitions revealed that the pain meant deterioration in his quality of life and uncontrollability, but was not seen as a disease. He believed that his phantom limb pain was neuropathic, due to a malfunction of the nerve system. He felt that he lacked confidence in managing the pain and that was consistent with the results of the Pain Self-Efficacy Questionnaire (PSEQ) (Nicholas, 1989). That is, his score on the PSEQ was below average, indicating low self-efficacy in pain control. With regard to treatment, MH did not expect any cure for his phantom limb pain and accepted its chronicity. However, he indicated that he would like to learn to control the pain himself, so he could once again enjoy his life.

CLINICAL FORMULATION

On the basis of the initial assessment, there were several hypotheses generated to guide the treatment. First, since there seemed to be a temporal relation between deterioration of MH's phantom limb pain and neighbourhood harassments, it was hypothesised that the pain had been exacerbated recently by the distress of these harassments. Second, it was hypothesised that the affective component of MH's pain was high because of his psychological distress resulting from neighbourhood harassments, recent increase in the pain, and pain related distress indicated in the results of WHYMPI. Third, uncontrollability, identified in the assessment, showed that MH had lost confidence in managing the pain himself. It was hypothesised that MH's usual coping strategies had not been sufficient and his self-efficacy in pain management was low.

Therefore, the treatment aims were to improve self-efficacy in pain management, to reduce affective pain, to reduce neighbourhood harassment related distress, and to improve pain self-management skills.

Suitability for Hypnosis and Application of Hypnosis to the Conditions

The use of hypnosis was considered suitable because there was no identified contraindication — for example, acute suicidality, major depression, or acute psychotic illness — in MH's case.

MH was considered a suitable candidate for hypnosis, as he believed in mind–body healing, was motivated for alternative treatment for pain, and responded well to pre-induction suggestions; that is, a series of waking suggestions that mimic the same types of behaviour commonly elicited under hypnosis (Udolf, 1981), including arm levitation and heaviness, hand clapping, and hand repulsion. In fact, Hammond (1990) argued that hypnotic responsiveness might not be as critical a factor in determining the selection of hypnosis for treating pain as was once believed. Thus reduction in the affective component of pain could be achieved with many people, regardless of their hypnotic responsiveness (Hammond, 1990). In particular, the affective component of the pain was assumed to be relatively high in MH's case. Hence, the application of hypnosis in managing MH's pain was considered most appropriate.

However, it was noted that MH was once told by a doctor to be cautious of hypnosis, as he could easily lose control to the hypnotist. Demystifying such beliefs required extensive education about common misconceptions of hypnosis and carefully conducted trials of hypnosis over a considerable number of sessions. No hypnotic analgesia was used before MH's trust in both the hypnotist and hypnotic procedures were apparently and adequately established.

Hypnosis has been historically used as a psychological technique for treatment of pain or induction of analgesic effects. Anecdotal evidence of hypnotic pain relief is abundant in various literature reviews (Chaves, 1986). Montgomery et al. (2000) and Hawkins (2001) have conducted meta-analyses of the effectiveness of hypnosis for pain treatment to arrive at the similar conclusion that hypnotic suggestion is an effective analgesic. Available evidence for the efficacy of hypnosis for pain was considered as level I evidence in light of the National Health and Medical Research Council guidelines (Hawkins, 2001). Therefore, hypnosis was undoubtedly an appropriate choice of treatment for MH's phantom limb pain.

Hypnotic Techniques (Rationale)

A combination of eye fixation and hand dropping was used as induction techniques, because MH was considered a kinaesthetic person and would respond well to bodily responses and movements. The deepening techniques were counting, visualisation (e.g., lying on a boat floating down a small river, taking a lift down, parachuting down, etc.), and eye fractionation. The reason for employing many deepening techniques was to achieve a desirable depth of hypnosis for maximising the efficacy of hypnotic analgesic (Hammond, 1990). Some of those deepening techniques were chosen according to his feedback. To alleviate MH's worry and affirm to him that he was under hypnosis, various hypnotic phenomena were demonstrated, including arm levitation, arm catalepsy, arm lightness and heaviness, visual hallucination, and sensory hallucination.

MH was trained in self-hypnosis by using the same techniques employed in the sessions (i.e., eye fixation and hand dropping as induction, and counting and visualisation as deepening techniques) with good effect. This provided continuation and consistency between home practice and in-session therapy. In line with the case formulation, some stress reduction techniques were also incorporated into hypnosis for eliciting relaxation and positive feelings. These techniques were progressive muscle relaxation, visual hallucination (e.g., safe place, garden, etc.), and recall of positive memories.

With regard to hypnotic techniques for pain control, a few of the therapist's pre-conceptual hypnotic techniques were formulated on the basis of MH's clinical presentations prior to the commencement of the intervention. These techniques and new ones were further formulated and developed on the basis of patient feedback. In general, all hypnotic suggestions used with MH were categorised and progressively trialled in the following order — dissociation, displacement, sensory substitutions, direct diminution of sensations, and direct anaesthesia (Hammond, 1990). It has been argued that direct anaesthesia is more suitable for one who is highly hypnotisable, whereas dissociation is effective for anyone low on hypnotisability (Hammond, 1990). Regardless of one's hypnotisability it is believed that, unless it is certain that a particular hypnotic suggestion is useful for an individual, it is appropriate in trialling hypnotic suggestions to range systematically from techniques effective for the majority to ones suitable only for high hypnotisable persons. Another reason for employing many different kinds of hypnotic suggestions is to enhance the patient's confidence in self-control over pain.

MH revealed that, for him, the concept of the analgesic glove and imagined painkiller injection (which was a recall of his previous pain relief experience at the hospital), among many suggestions, were most effective. Therefore, hypnotic suggestions of sock and bandages for his left foot acting as analgesia and protection were also formulated for MH as alternatives. These suggestions fitted well with his pain description.

Post-hypnotic suggestions were carefully used to extend the in-session hypnotic benefits. For example, the following post-hypnotic suggestions were used at the end of each treatment session: “Whenever you need to feel relief from this pain, you’ll suddenly notice that, in fact, you are beginning to feel better; and you will feel better throughout the day” (Hammond, 1990); and “Whenever, you notice the pain in your left foot, you’ll suddenly notice that, in fact, your left hand is beginning to feel comfortably numb, like the anaesthetic glove has already been put on; you’ll be able to apply the anaesthetic numbness from your left hand to your left foot; you’ll feel comfortably numb on your left foot throughout the day.” It is argued that post-hypnotic suggestions can work well in a patient’s unconscious intentions to let pain run its own course from start to finish. This rationale for the use of post-hypnotic suggestion is regarded in MH’s case as highly relevant, since MH’s pain does have a course of its own to run, with its onset occurring at early evening and its cessation taking place late at night. Post-hypnotic suggestions could be used to perhaps shorten the natural course of MH’s phantom limb pain. Therefore, the duration of pain suffering would be reduced.

THERAPEUTIC GOALS

In addition to cognitive behavioural therapy for MH’s phantom limb pain, the therapeutic goals of hypnosis were as follows:

1. To decrease sensory and affective components of pain, and of neighbourhood-dispute distress;
2. To improve self-efficacy in pain self-management; and
3. To increase pain coping strategies for pain self-management.

It was emphasised to MH that pain eradication per se was never the main aim of the hypnotic intervention.

Reflections on Therapy Application

Despite the fact that MH had responded very well to hypnotic treatment and successfully learned self-hypnosis, there was a major difficulty in applying

and evaluating hypnotic analgesic techniques. MH's phantom limb pain only occurred at night, but not during the session. Therefore, hypnotic pain control or reduction was unable to be achieved during the session with the therapist. To resolve this difficulty, two options were initially proposed and trialed with MH. First, the phantom limb pain would be induced during the session for testing any hypnotic analgesic techniques. Second, through self-hypnosis, MH could trial any technique himself during the evening when the pain occurred and provide feedback to the therapist.

MH decided that both options were worth trying. The first option failed, as only minimal phantom limb pain was able to be induced by hypnosis within the session. The second option then became the main focus of the treatment for a period of time. However, a third option of using audiotaped scripts was generated later in the treatment. An audiotape of hypnotic analgesic was prepared for use at night when his pain occurred. Through MH's self-hypnosis practice and the therapist's audiotape, MH was able to identify a number of effective hypnotic techniques for pain control. The fact that the application and evaluation of hypnotic analgesic technique relied very much on MH's self-hypnosis practice, instead of the in-session practice with the therapist, enhanced MH's self-efficacy significantly, his active participation, and his motivation for treatment. This led MH to believe that it was he, himself, who generated the techniques and made them work.

MH found that the hypnotic technique of imagining being injected with pethidine was most effective, as it was connected to his past experiences at the hospital. This confirmed the effectiveness of utilising patients' previous experiences for generating hypnotic techniques for pain control.

OUTCOMES

The hypnosis treatment was completed over 20 weekly sessions. After the initial six sessions of accustoming MH to hypnosis, he had already reported feeling more relaxed and calmer. The self-hypnosis training then commenced. MH learned self-hypnosis very well over four sessions. During his learning of self-hypnosis, his distress was alleviated significantly. At the same time, MH's confidence improved, as he believed that there was something he could do to manage a condition he had previously found uncontrollable. The hypnotic interventions for his phantom limb pain were completed in five sessions. MH reported that his pain improved significantly for two weeks. The pain severity was reduced and the daily onset of pain had been delayed to late at night.

MH reported that he did not even notice much of the pain when it occurred during his sleep. His affective pain reduced significantly, as he commented that he had had less pain-related distress and had seen some hope in his life. For example, he reported that he has restarted work on his invention, which he had postponed due to the severe pain problem.

However, for a period of two weeks MH's phantom pain flared up. This was reframed as an opportunity for further training of pain control through self-hypnosis. Subsequently, MH's pain settled back down to the original pattern of coming on in the evening. This was then followed by a period of two weeks with less pain and more continuous improvement. MH reported an increase in confidence in self-hypnosis. He believed that he could reduce the phantom limb pain significantly for half of the time through self-hypnosis and would achieve more sensation control (no feeling in his left leg). Moreover, his affective pain still remained low. MH described a few episodes of successful self-hypnosis in controlling the severe pain. For instance, during one evening, when he had severe phantom pain, rated by him as 10/10 on the pain scale, he decided to try self-hypnosis for pain control. To his surprise, within a minute of his self-hypnosis the pain started to subside and disappeared for the whole evening. Also, the nature of the phantom limb pain changed from pain on his left heel and toes to only his left toes.

The remaining five sessions were focused on maintenance of therapeutic effects, relapse-prevention, and CBT techniques for managing neighbourhood-dispute distress. Audiotapes of several preferred hypnotic analgesia techniques by the therapist were also prepared for MH.

GENERAL DISCUSSION

There are several noteworthy features of this case. First, rapid reduction in affective pain was evident soon after the commencement of the treatment, even though sensory pain remained unchanged. MH felt less distressed, more confident, and hopeful. This supported one of the initial hypotheses that the affective pain was high and should be the target for intervention. This result is consistent with the literature that hypnosis is effective in controlling affective pain, regardless of hypnotisability. Thus it might not be unreasonable to believe that hypnosis would be beneficial to the majority of pain sufferers, at least in relieving affective pain. It could be integrated well into the mainstream pain management program.

Second, patients' active and continuous feedback is of considerable

importance in formulating and developing effective hypnotic techniques for pain control. Indeed patients' phenomenology of the pain experience contributes greatly to the choices of hypnotic techniques. This supports the therapist's belief that hypnosis is an interactive and collaborative process in which both the therapist and client have an active role, rather than a passive approach where the therapist, like a superior, reins in the client's problem and the client is passively receiving the solution.

Third, since the meaning of pain and suffering is as important as the pain itself, the hypnosis sessions also aimed to change MH's interpretation of his pain and suffering. Significantly, MH learned through hypnosis that he did not need to suffer from the ongoing phantom limb pain, as there was an effective pain self-control technique, self-hypnosis, available to him and that he had control over what he initially thought was uncontrollable pain. Therefore, the phantom pain did not mean a passive suffering anymore, but active management of it. Also, MH's self-efficacy in pain management would be enhanced.

It is also noted that hypnosis was not the sole treatment for his phantom limb pain. Psychoeducation and cognitive behavioural therapy for chronic pain were also employed with the aims of decreasing MH's medication use, increasing his functioning, increasing his pain self-management skills, improving his mood and improving his coping with the neighbourhood-dispute distress. Strategies such as the installation of fire alarms and of a closed circuit TV system for personal safety at home were also generated during the treatment to enhance MH's sense of safety and to alleviate his distress.

It is believed that phantom pain is a complex phenomenon. Pain reduction alone is often insufficient in treating distressed pain patients. Only if the other factors that are affecting patients' pain experiences are also addressed in the treatment will the efficacy of hypnosis be maximised.

The final interesting aspect of MH's case is that the use of a hypnosis tape was introduced later in the therapy, although tapes could have been effective in training of self-hypnosis earlier in therapy. This late introduction was done for two reasons. First, since one of the treatment aims was to improve MH's self-efficacy in pain management, early introduction of an audiotape of the therapist's hypnosis would become a hindrance to development of his self-confidence in doing hypnosis and his self-efficacy in controlling the pain through hypnosis. Therefore, the late introduction of the tape could be considered as a therapeutic tactic that worked well for MH. Second, general dependence on audiotape and/or therapist would be prevented and the patient's belief that self-hypnosis was possible could be established.

CONCLUSION

The present case shows the effectiveness of hypnosis in treating phantom limb pain, in particular, alleviating affective components of pain and as an adjunct to the conventional cognitive behaviour therapy for chronic pain.

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CASE NOTES

HYPNOSIS: AN ADJUNCT TO COGNITIVE BEHAVIOUR THERAPY

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This case illustrates the successful use of hypnosis as an adjunct to cognitive behaviour therapy with a 28-year-old female. The client presented with gambling issues, occasional bulimic behaviours, poor self-esteem, and a moderate level of depression. Cognitive behaviour interventions were used initially to gain a baseline of her behaviours, as well as knowledge of the problem's severity. Some cognitive restructuring and behavioural interventions were put into place. A relaxation tape was recorded for the client to practise lowering anxiety at her home. Assertiveness training was taught, and hypnosis was used for ego strengthening. During subsequent sessions, hypnotic regression successfully highlighted the underpinnings of her unwanted behaviour. Finally, the client was able to rid herself of excessive negative emotions by the use of imagery to discard a receptacle filled with the unnecessary feelings.

PRESENTING PROBLEM

Kerry self-referred with reports of bulimic behaviours and gambling issues. She also reported having low self-esteem, and that her work, family life, and social functioning were beginning to be affected. On presentation, she was polite and cooperative, although appearing somewhat anxious and avoiding eye contact at times. There were some repetitive motor behaviours. She apologised constantly and an assessment of her mood indicated a moderate level of depression. Recent blood tests had found that her testosterone levels were double what they should have been. Subsequent to this finding she had also become preoccupied with worry about lesbianism. Her sex life was not good. Otherwise Kerry was in good health physically. She stated that her

problems had worsened gradually over the last couple of years. She had been prescribed medication to regulate her hormones and reported that her levels were beginning to normalise.

Just prior to making her appointment with me she received a phone call from her estranged parents saying they were coming to visit her. She was extremely distressed at the thought, but felt unable to tell them.

HISTORY

Kerry was a 28-year-old married woman with a six-year-old son. She was strikingly attractive and had been married for seven years to a man whom she described as loving, understanding, kind, and supportive. Kerry and her brother were brought up in various parts of Queensland, having “moved house too many times to remember.” She stated that her mother was “totally mad” and behaved in inappropriate ways in social situations. She constantly criticised and made derogatory or sarcastic comments about her children’s appearance. Kerry described her mother as cold, unemotional, strict, and unpredictable, while her father was unable to make decisions. She reported being frightened by her father, who also drank a lot. However, he would passively do whatever her mother wanted.

Kerry emphasised that there had been no physical or sexual abuse by her parents. She had performed well at school and eventually completed a degree in horticulture at university. She rarely communicated with her parents after she had married and they “now spent their lives touring around Australia.” Kerry looked after their finances for them while they toured, but only spoke to them when she had to. She was part owner in a lucrative business with her husband and mother-in-law. There were some issues with her mother-in-law but she did not feel they were a priority.

DIAGNOSIS

Kerry did not meet the criteria for a DSM-IV (American Psychiatric Association, 1994) diagnosis of a specific disorder. Eating and gambling disorders can frequently be symptoms of a problem rather than the problem itself (Emmerson, 1999). Her weight appeared normal. It was my belief that she was using behaviours that gave her a sense of control to compensate for feelings of inadequacy and poor self-esteem relating to her childhood. I assessed her worry about lesbianism as understandable due to the blood-test results and in the context of her depressed mood. I found no cognitive or behavioural indications of underlying problems with her sexuality.

TREATMENT

Sessions 1–4

The first four sessions were focused on gathering information. I explored, in more depth, her relationship with her family of origin, her abnormal eating habits, the gambling problems, and relationship dynamics with her husband and mother-in-law. Eating and gambling problems usually worsened as her levels of anxiety increased. Cognitive behaviour interventions were used to gain a baseline of her behaviours, as well as knowledge of the problem's severity. Some cognitive restructuring and behavioural interventions were put into place, such as written thought challenging and changes in routines around the house where food was involved. I recorded a relaxation session with Kerry, so that at home she could practise lowering her base levels of anxiety. Together with psychoeducation, I also used assertiveness training and other cognitive behavioural interventions. Kerry wrote letters to her mother and father about her feelings, although she did not post them. She began practising assertiveness at work towards her mother-in-law, staff, and clients. She was making rapid improvements and reported that her husband was thrilled with her progress. Her sex life was improving and the level of depression began to decrease with the use of cognitive restructuring. Her gambling behaviour had stopped, but binge eating still occurred. During the four sessions, it was becoming evident that Kerry was competent, creative, and very bright. She was highly motivated to change.

Session 5

At this session, Kerry presented as quite depressed. She had been in contact with her mother by phone and reportedly “went downhill from there.” When I tried to explore what had happened, I noticed that Kerry frequently used the phrase “hmmm, I don’t know.” I felt there was something she had not told me, but I believed she did not know what it was. She had always been willing to share information. Since we had established good rapport, I spoke to her about the researched usefulness of hypnosis to augment the cognitive behaviour therapy she was already undergoing (Shoenberger, 2000). I suggested that hypnosis might even allow her to find out exactly what it was that she did not know, although it may not be at this session. She appeared enthusiastic, having no concerns about losing control or being able to relax. Kerry signed a consent form to undergo hypnosis.

I used progressive muscle relaxation as an induction, and walking down steps to a bay at the beach for deepening. Kerry established her safe place, and I used ego-strengthening suggestions to assist with issues of self-esteem, to roughly assess her level of suggestibility, and allow her to sample the hypnotic experience. She responded very well and reported having a great experience. Her mood had improved, in contrast to the time when she had first arrived. I suggested that we could explore what she did not know next week.

Session 6

Kerry stated that she had had a good week. She had thoroughly enjoyed the hypnosis and was dealing with life and work in a more confident and efficient way. She was no longer constantly apologising. She still was not gambling, and noticed that her worry about lesbianism had gone. However, she was still binge eating and very nervous about her parents' impending arrival. I asked Kerry if she would be willing to experience age regression during hypnosis to further explore the intense feelings towards her mother. She agreed, and after an induction, deepening, and establishment of a safe place the affect bridge was used as an age regression technique. Approximately 15 minutes into the session, Kerry's face became very white; she began to breathe faster, became teary, and clasped together her previously relaxed hands. The reaction lasted for about 20 seconds and when I quietly told her everything was fine she began to relax once more. At the end of the session, and after orientating herself back to the room, I asked if she wanted to discuss what had happened for her at that moment. She very quickly defined the experience as an overwhelming feeling of guilt. Hesitantly and tearily, she reported that eight years ago she had become pregnant with a previous boyfriend and was pressured by her mother into having an abortion. She stated that she had not experienced a guilt-free day since that time, and was probably blaming her mother for it too. Kerry had never told this to anyone before. We discussed the events surrounding the abortion in more detail. I checked that she was feeling well psychologically and physically, and ended the session by suggesting that next week she might consider hypnosis to finally dispense with feelings of unnecessary guilt.

Session 7

Kerry came to this session stating how much lighter she felt. However, she was disappointed in herself that she had still not been able to control her

eating, although she had only binged once. After induction, deepening, and establishment of a safe place, I suggested that Kerry go to a private place and visualise herself walking along a very pleasant path. She could find a receptacle of her choice and fill it with as much unnecessary guilt as she needed to, along with any other negative emotions that had served their purpose. She could then bury, hide, or throw away the receptacle and come back to her safe place. Using imagery, I encouraged the use of Kerry's submodalities to experience present success, lack of guilt, assertiveness, control, accomplishment, and lack of fear. Future imagery was then suggested, so that she could transport the thoughts and feelings to future settings. She was able to visualise herself in many situations, behaving assertively to her mother, having finished with guilt over the abortion, and having taken back control of her life. She left my office with a very broad smile.

Session 8

Kerry came back three weeks later. She walked into my office and suddenly stopped. I asked what was wrong. She said that opening my office door had reminded that she had experienced no guilt since her last visit. She stated that she had not binged either. She had also had the visit from her parents. She reported having been assertive, confident, and anxiety-free during the visit. Her mother, however, appeared totally confused and hardly spoke. "She was almost mouse-like. I kept finding her just looking at me," stated Kerry with a smile.

OUTCOME

Kerry's sessions were spaced further apart, and after that she still came to see me from time to time for mentoring or coaching with respect to the running of her business and her interaction with employees. Her problems with her mother-in-law were no longer an issue. Kerry reports feeling empowered during interactions with her parents and states that the relationship has been changing in positive ways. She has not gambled or binged since the last hypnosis session. Neither does she experience any excessive guilt relating to the abortion. She stated that she has taken back her power and not only knows herself much better, but likes herself too.

CONCLUSION

This case study highlighted the successful use of hypnosis as an adjunct to cognitive behaviour therapy in the treatment of eating problems, gambling

issues, poor self-esteem, and persistent negative emotions. Hypnosis was useful in uncovering the underpinnings of these behaviours by use of the affect bridge and facilitated the letting go of coping strategies that had served their purpose, by use of a receptacle which she would fill with negative affect and then discard. The implementation of submodalities in imagery facilitated attention to present life successes as reminders of her capabilities. Furthermore, the trance state was used to enable future imagery of the way she wanted to be and feel in various situations. Lastly, according to Emerson (2000), when symptoms persist despite relevant treatment it is possible the client has painful issues that have been suppressed. Hypnosis, to explore underlying unconscious feelings, proved to be extremely useful.

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WORKING WITH THE INNER ANIMALS IN VISUALISATION

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This article introduces a method of guided imagery called the Personal Totem Pole Process (PTPP), which is a unique blend of Jungian active imagination, the chakra system, and ancient shamanism. The work with “inner animals” is crucial to this method. Applications to therapeutic work with various clients are discussed. Additional information about some aspects of this approach is supplied by Dr June Henry at the end of the article.

There are many ways to work with visualisation in therapy, for example, guided imagery, the directed daydream (Desoille, 1966), psycho-imagination (Shorr, 1983, 1998), guided affective imagery (Leuner, 1969, 1975), and of course Jung’s method of active imagination. One of the oldest methods is the shamanic journeying, which many New Age therapists still use (Harner, 1990). In a previous article (Claudewitz, 2003) I outlined a hypnotherapeutic method called the Personal Totem Pole Process (PTPP) which has been developed by the American psychologist Stephen Gallegos. The method is a unique blend of Jungian active imagination, the chakra system, and the ancient shamanic practice of speaking to, and learning from, the animals, but Gallegos has excluded the many superstitious elements and rituals of traditional shamanism. No drums are used to induce the trance state, and a general progressive relaxation technique is utilised. After the induction, the client is told to imagine that an animal emerges from each of the seven chakras. This paper will present further therapeutic work with the “inner animals.”

According to Eastern tradition, the chakras are vertically aligned energy centres in the body, running from the base of the spine to the crown of the head. They seem to correspond to important points of acupuncture

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(Motoyama, 1984). Ancient tradition states that certain elements, colours, and sounds are connected to them. Also, most of the chakras have specific animals associated with them, that is, an elephant should be connected to the ground chakra, an alligator to the belly chakra, a ram to the solar plexus, a gazelle (or an antelope) to the heart, a white elephant to the throat chakra, but no animals are associated with the forehead and the top of the head. However, those who are familiar with the Personal Totem Pole Process will know that this is not true. It may have been the truth for the yogi who discovered the system ages ago — he probably experienced these animals in his own chakras and then thought that they applied to all mankind. But Gallegos (1983, 1987) found that people imagine different animals coming out from each chakra and that these animals are symbols from the unconscious.

Many of the insights that C. G. Jung acquired he attributed to a wisdom figure named Philemon, who appeared to him during his inner exploration using the method of active imagination. Philemon was a cross between a man and an animal, and in many ways he became Jung's inner adviser and teacher. Philemon was not just a simple fantasy figure, but "represented a force, which was not myself ... It was he who taught me psychic objectivity, the reality of the psyche" (Jung, 1973, p. 183). The chakra animals are also inner guides, just like Jung's Philemon. They have a reality of their own, with a particular consciousness and personality. They also have a profound knowledge of what the person needs to experience to achieve inner healing and personal growth. We are here interacting with the actual autonomy of the unconscious — just like in a dream.

The Procedure

The chakras are said to be connected to our thinking, feeling and willing, and Jung recognised the symbolic significance of the animals located in the chakras (Jung, 1999).

In Gallegos' method, the client is told to relax and then to focus his attention on, for example, his heart chakra. According to yogic teachings, alternations of consciousness are inherently linked to the operations of the chakras; thus focusing on a specific chakra should produce some kind of a trance state. Then the client is asked to imagine an animal coming out from his heart. When the animal has emerged, the client is encouraged to greet the animal and to thank it for coming. It is also asked to tell you something about itself and if it needs something from the client. The procedure is repeated until the client

has met with all seven chakra animals. The technique in many ways resembles John Watkins' method of ego state therapy (Watkins & Watkins, 1997), but it is much easier to call out an animal from a specific body part than to contact a hidden ego state.

The Stages of the Process

The varieties of the PTPP fall into three basic stages. The first stage is: meeting the animal. For some (especially very anxious clients), this process can be strenuous. Sometimes, the animal cannot be seen at all. It may instead be heard, felt, or even smelled. A young woman experienced no chakra animals at all, but every time she tried to call them out she immediately felt a tremendous headache. Clearly, something wanted to come out, but her conscious mind was not yet ready for the meeting with the subconscious part. Another client imagined 50 butterflies emerging from the ground chakra at the base of her spine. In such cases the therapist can suggest that the animals merge together in order to heal that split in the psyche. In this way there will be a relocation of energy symbolised by the new animal figure that will emerge from the process. When the butterflies merged, they transformed themselves into a beautiful orange bird.

The second stage is to develop a relationship with the inner animal. It is, in many ways, the most practical, personal level. Sometimes, a dialogue is quickly established, but it may happen that the animal is completely silent. In such cases, the therapist can suggest that the client simply ask the animal: "Why don't you want to talk with me?" If the animal still does not respond he can suggest that the client approach it in a non-verbal way, for example by touching or stroking it. In this way, the client shows the animal (i.e., that part of the personality) that he accepts and cares for it. When a positive relationship has been developed, the animal will lead the client into hidden channels of his mind. The mind will begin to create dramas to help it cope with different situations. It is the language of the unconscious and it deals with problems metaphorically, rather than directly.

The third stage is journeying with the animal in the collective unconscious or the archetypal realm. The therapeutic effect of such a mental journey can be almost magical, both during the creative process and when the client looks at it afterwards.

However, not all clients are willing to journey with their inner animals. It should be remembered that an encounter with the collective unconscious

exposes one to the same contents that appear in psychosis, and this can be very frightening for some people. The reason why the involvement looks very much like a psychosis is that the client is integrating the same fantasy material to which the insane person falls victim, and who, because he cannot integrate it, is swallowed up by it (Jung, 1972). But there can also be other reasons for the unwillingness to journey; for example, fear of change can sometimes be a significant factor. A very hypochondriac patient encountered a blackbird from her heart chakra, and it invited her on an inner journey, but she adamantly refused to journey with the animal and said: "I will rather stay here in my misery!" It turned out that she was not prepared to give up her "illness," since she had a substantial amount of secondary gain from it because her doctor, family, and friends felt sorry for her and thus gave her a lot of attention. The response from the blackbird was that it immediately dropped dead. That reaction made her start a deeper process of reflection on her sickness and she eventually became totally cured of her hypochondria.

A young woman suffering from a severe eating disorder had for some time only experienced strange fantasy creatures coming from her chakras, but at one point a "real" animal turned up in her imagination. A white horse came to her and it invited her on an inner journey. The meeting with this animal had a deep emotional impact on her and she started to cry. The horse took her on a long ride into a desert and then put her down at an oasis. Here she could relax completely. At our next session about a week later she told me that now she had begun to eat more normally. Also, her menstrual period which had been absent for more than two years had started again. The mythical journey with the horse really marked a turning point in her life.

Sometimes the inner journeys cannot be completed during a traditional one hour session, but if the journey has to be interrupted the therapist can ask the animal guide if it is okay to stop now and continue the journey at the next therapy session. Usually, this is accepted by the animal. The therapist can also suggest to the client that he — before the journey starts — tell his animals that they only have a certain amount of time available. This usually works well, but the pitfall is that some clients may get quite nervous, because they feel that things must be rushed.

Active Imagination and Fantasy

Jung often pointed out that active imagination is not so much a technique as it is a natural process. But how can we, in meeting the inner animals, know

active imagination is really taking place rather than fantasy, daydreaming, or reverie? Fantasy in itself does not constitute changes. According to Hall (1989) there is only one sure criterion and that is when something unexpected and startling happens that is not the person's voluntary creation. The unexpected and surprising events show the autonomy of the unconscious processes. For example, a depressed client called an animal from her solar plexus chakra (her personal power centre) and suddenly she felt very hot in that area. She experienced flames coming out of her body and shortly afterwards she imagined a dragon emerging from her solar plexus area. This was a complete surprise for her. After she had collected herself, she addressed the dragon, asking it what it needed from her. It immediately became afraid and curled itself up and in this way it probably reflected the problems she had with expressing her own needs. It also constantly changed its colours. Then it invited her to follow it into a dark cave, which had a small opening in the roof at the far end that allowed light to come in. Inside the cave, the dragon allowed her to sit on its back. From the throat chakra (i.e., her communication centre) emerged an octopus which was guarding the entrance to a cave. It changed its colour when she addressed it, but it did not allow her to enter the cave. This client was very secretive about herself.

The Other Side of the Chakra Animals

Some time ago, I discovered that the chakra animals also have "back sides." The term "back side" of the chakra animal has nothing to do with the back of the animal or the bottom or anus. If I, for example, have called out an animal from the middle of a client's forehead (also called "the third eye"), then I proceed and tell the client to focus his attention on the back side of his head aligned exactly with the "third eye" and imagine that an animal comes out from this position.

To determine the procedure, I looked at a map over the acupuncture points and noted that there are acupuncture points that are horizontally aligned with five of the main chakras, but not with the ground and crown chakra. Some esoteric writers (e.g., Tansley, 1982) claim that the chakras actually are located along the spinal column, even though most books on the subject show them on the front of the torso. Nevertheless, the question for me was: Would my clients be able to imagine an animal coming from the "back side" of the second to the sixth chakra? I began to experiment to see what they would experience. It turned out that there actually are animals emerging from the

back side of these five chakras, and sometimes they are more willing to show themselves and talk than the animals from the “normal” front side. They often even seem to express something much deeper than the “ordinary” chakra animals are willing to come forward with. For example, I worked with a man who experienced a wolf coming out from his forehead. It did not want to have any close contact with him and it quickly disappeared into a cave. But from the back side of this chakra, a big bear emerged. It embraced him and said that it very much needed his affection and love, because it had felt neglected for such a long time. No animal emerged from his throat, but from the back side of this chakra he experienced a seahorse which immediately began to criticise him. Then it told him that it was his father and at that moment it transformed itself into a giant snake, which frightened the man very much. The snake also said that it controlled him because it had eaten the animal from his throat. Then an eagle appeared which said, “That is not true” and it attacked the snake, but did not kill it. In the after-talk, the client said that he had always felt inhibited in expressing himself. His father had always put him down for as long as he could remember. However, the encounter with the powerful eagle gave him much more self-confidence.

Another client experienced a vulture coming out of her solar plexus area telling her that it was her father. She always had been very afraid of him and this animal scared her a lot. However, from the back side of this chakra she imagined a ferocious lion, which was not afraid of anything and wanted to attack the vulture. It seemed that the vulture had taken up the place of her own power animal, the lion, which now wanted to regain its rightful place.

A client experienced a fish coming out of his sixth chakra in the middle of the forehead. The fish wanted him to float in the water and just relax. But from the back side of this chakra a furious crocodile emerged and it frightened him very much. The crocodile had been locked up in a cage during most of its life and now it wanted to get out! It even showed him a picture of himself as a child who had to be set free.

The “back side chakra animals” seem to represent very deep unconscious behavioural tendencies inside us, in many ways similar to Jung’s concept of the “shadow.” How do I call out these animals? First I call out the animal from, for example, the forehead. If it turns up and the client develops a relationship with that animal, then I proceed and tell the client to focus his attention on the back side of the head aligned exactly with the “third eye” and imagine that an animal emerges from this position. Sometimes, I tell the client that now he is going to encounter the “back side of his chakra animal.” Most clients are

very excited and curious about this exploration. After the client has met both animals, I suggest that the two animals meet each other. Since there can be a very big difference in the character of these animals, such a meeting may not be peaceful at all. However, if the two animals accept each other I sometimes suggest that they merge together. Usually, they are not very willing to do that, perhaps because they often are so different from each other.

A Clinical Case Story

I shall here briefly describe a therapy with a 27-year-old woman with whom I worked for almost a year. She had been diagnosed with ovarian cancer and she also suffered from OCD. The cancer had already spread throughout her body and the doctors had only given her a short time to live. During the period I saw her she did not undergo chemical or radiation therapy. A tumour had squeezed her urinary tract so much that she had to have a urostomy performed. She had a very strict religious upbringing and she had not been allowed much leash in her teenage years.

From her abdomen, she encountered an elephant and a giraffe. Both these animals scared her a lot, because she perceived them as foreign bodies representing the cancer cells and she told them to go away. The animals were very surprised at her reaction and told her that they had come just to help her, but that did not change her attitude towards them. From her throat chakra appeared a lizard which said to her: "You are stupid because you always do what your father wants instead of enjoying your life." Then the lizard went into a swamp where it transformed itself into a grumpy crocodile. From her heart chakra came a worm saying to her: "You need to relax so that you can heal!" From the solar plexus, she encountered a small grey mouse, which led her through a tunnel into a green landscape. Here she met a big snake that told her it was very angry. It even bit her in the face because it wanted her to wake up. From her forehead came a roaring lion and a caterpillar. The lion immediately ate the caterpillar because it wanted to prove that it was the stronger. Then it showed her a snow landscape. From the top of her head came a zebra which took her to see the savannah where it lived.

When all these animals met, they formed a circle around her and shone a healing light from their hearts onto her. She immediately felt a strong heat and afterwards she experienced a whole new energy in her body.

At a later session she encountered the animal of the cancer which was a crocodile — the same animal that she had encountered from her throat. It scared her very much, but amazingly it told her to relax. Then I asked her

to call for an animal of healing. An elephant appeared and it invited her to journey with it inside her body. During the journey they encountered a big white cancer tumour in her left side. The elephant started to blow on it and suddenly she felt very hot in her left side. In her imagination, she saw the tumour slowly diminish and eventually disappear. Afterwards, the elephant continued the journey to heal her abdomen.

At our next session a couple of weeks later she told me that her urinary tract — much to her doctor's surprise — now was functioning normally again. The tumour which had squeezed it apparently had disappeared and the doctors had now removed her stomy pouch, which was a great relief for her. It is of course difficult to say if this was a direct result of the imagery journey, but there is some evidence that patients can influence their immune system by specific imagery (Achterberg, 1984; Hannigan, 2001). Imagining large animals (like an elephant) fighting the cancer cells also seem to have a positive effect on the disease (Achterberg, 1984).

A couple of months later, I invited the client to meet the chakra animals again. Now the animal from her throat had transformed into a pelican, which told her that she was on the right track. But this time I also called out the animal from the back side of the chakra and a snake with black stripes appeared. It told her that she was up against more than she could match and that she eventually would die of the disease. Unfortunately, it later turned out that the snake was telling her the naked truth.

During almost all her life, she had had obsessive thoughts and when she was diagnosed with cancer these thoughts grew even stronger. For example, she felt compelled to tell herself at least a thousand times daily that she would get well again. This was a terrible torment for her. However, the work with the inner animals helped her to relax and at one point I asked her if there was an animal that could help her when these obsessive thoughts came up. A polar bear with a “stop signal” in its paw appeared in her imagination. Afterwards, she was able to control her anxious thoughts with the help of the bear and that was a tremendous relief for her in the last months of her life.

In a session shortly before she died, she encountered the “animal of death.” It was a small white mouse which said to her: “Don't be afraid.” She also met the “animal of life” and it was a black snake which scared her a lot. In the after-talk she told me that she was much more afraid to live than to die, because she did not really know how to live. After almost a year of therapy she passed away. However, I believe that the meeting with the inner animals gave her extra strength to deal with her extremely difficult situation.

Working with Tobacco Addiction

The PTPP can also be used in working with tobacco addiction. The therapist can for example call out an “animal for the addiction” or he can ask the client to imagine that an animal emerges from each of his lungs. Meeting the animal of the addiction gives the client an opportunity to ask the animal when and why it came into his life, what it needs from him, and whether it will agree to leave him. Meeting the animals of the lungs can on the other hand be a horrifying experience. If the client, for example, has been a heavy smoker for a considerable number of years there may be living ugly black monsters in his lungs feeding on tar and smoke. Such an experience can really be a deterrent — and a strong motivating factor for the client to quit smoking.

Creative Combination with Other Visualisation Techniques

In 1987 Tajima and Naruse described a special form of psychotherapy, tsubo imagery psychotherapy, in which the client is asked to imagine that he enters a tsubo, which is an oriental jar or pot. The technique, in many ways, resembles the traditional shamanic journeying where the person visualises that he enters an opening into the earth and then follows a cave or tunnel downward (Harner, 1990).

Many different kinds of emotions can arise depending on what the client encounters inside the jar. However, the problem with this method is that the client is journeying alone inside the tsubo, that is, he has no “steering wheel” or guide and this can result in a lot of unnecessary anxiety in some clients. Therefore, I developed a technique where the client first calls for an animal which is willing to accompany him during the journey into the jar. Almost always an animal will emerge as a travelling companion.

I will here present a few clinical examples of this work. A very anxious and depressed woman with low self-esteem journeyed into the tsubo and found a letter which read: “Dear R. You are great! Don’t be afraid. Everything will be fine, if you just will allow yourself to relax.” In another tsubo, she encountered a rat which also told her to relax. When she agreed to do that, it immediately transformed itself into a happy squirrel.

Another client imagined three tsubos. She journeyed into the first accompanied by a dog and discovered Aladdin’s cave, where she found a big treasure. In the second tsubo, there was a storm raging and a lot of noise. In the third, she found a cave with a lake. Here, she felt a great relief and an inner calmness she had not experienced before in her life.

The animal work can successfully be combined with the tsubo imagery technique by calling for an animal guide before the client enters the jar. This reduces anxiety because it gives the client a sense of some control of the imagination.

Conclusion

To live in harmony with the world around them, clients need to live in harmony with themselves. The PTPP is a very versatile hypnotherapeutic method to find inner peace and to discover both powerful and creative resources in oneself and it can be used with many different types of psychological problems. It also helps the client acquire a better understanding of the self and the inner parts that constitute the self.

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Endnote

One interpretation of the Tantric chakra symbology is as a codification of a pathway of disengagement, with pictorial terms/metaphors as descriptors for qualities of the experiential states passed through on the way of unification of consciousness. From this perspective on Tantric metaphors, the animals, gods and goddesses, mantras, and symbols drawn in each Tantric chakra representation might be viewed as attempts to “describe the undecipherable,” the quality of the experience of alternate states of consciousness (said to be the “planes” and living abodes of the gods and goddesses) rather than emerging symbols from the personal unconscious.

A useful analogy to assist interpretation and comparison might be offered by the more recognisable codification of a pathway of disengagement offered by the Royal Road of Patanjali, the scientist who uses a more verbal approach in attempting to describe the indescribable pathway to unification of consciousness.

The interpretation of Tantric metaphors/symbols as a pathway of disengagement provide some particularly useful reflections on the codification of the upper chakras where the symbols, goddesses, are drawn on the different parts of the face, for example, the lips or eyes.

The question has to be asked if the ancient Tantric yogis were codifying hypotheses about many differing pathways of psychophysiological activation, starting from stimulation at the sites of these organs (e.g., the eyes), and Tratak awareness of the lips in Yoga Nidra, and leading to different alternate levels of consciousness as depicted by the animals, goddesses, and symbols. As has been said in the Ancient Wisdom, the onion has many layers.

The symbology of the upper forehead chakra, Agnya, as a metaphor for the uniting of the two flows of consciousness has been outlined well by Ernest Rossi with his outgoing expressive and ingoing receptive flow; and the Sahasrar, an upper chakra, drawn as a petalled lotus cap on the head of meditator, has been interpreted by some psychoanalysts and the ancient Tantrics as the flowering or blossoming of the unconscious. These might be seen as alerting us to the use of animals to describe the qualities of the ASC, rather than the emergence of forms of the personal unconscious.

In drawing together impressions, the author is to be congratulated for drawing our attention to the great visualisation approaches, “flowerings” of the East and West. It is to be hoped the author will stimulate some lively interaction in this area.

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SCRIPTS

TRUE GRIT: WE NEED TO QUIT – A HYPNOTIC SCRIPT★

Ted Graham
Psychologist

The following hypnotic script is premised on empowerment through client knowledge of mental processes and grew out of the unacceptably high failure rate of a prior quit-smoking methodology. The initial process utilised cognitive and behavioural practice along with a hypnotic script which was tailored to a client's needs and was thus subtly different for each client. Relapse rates were unacceptable, although exact numbers were not maintained. From a private practice perspective, it appeared that an immediate improvement in technique and a boost to a less than confident therapist's demeanor was warranted.

OVERVIEW

A literature search of quit-smoking methods with and without hypnosis, and behaviour change methods, led to the protocol briefly outlined, for which the hypnotic script below was developed. Each topic requires an extensive literature which would render a full evaluation of each topic well beyond the brief overview intended. The following concepts and theories did not appear to feature in any of the observed quit-smoking protocols.

Research carried out as part of a master's dissertation supported the model and process whereby the model combined with the hypnotic script evinced a successful quit-smoking outcome at one month post quit date ($p < 0.02$) when contrasted with a control. Chemical verification was not sought.

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★Further information on the quit-smoking kit developed by the author can be directed via email to tgraham7@bigpond.com.

Ironic Processes

Thought stopping (Wolpe, 1958) and thought stopping with covert assertion (Rimm, 1973) were integrated with ironic processes of mental control (Wegner, 1994) to address clients' major problems of why it appears so difficult to quit smoking. Wegner (1994) found that it is counterproductive to try to remove negative feelings or thoughts from consciousness. His research suggests that it might be prudent to admit a feeling or desire. It follows that to do so will reduce tension whereby the client (respondent) might then use an assertive cognitive process to reprogram memory. Thus quitting could be less onerous than previously experienced during a denial process.

Learning

Recent research suggests that learning and hence memory consolidation is a time-dependent process which is slow when compared to a computer. This may be because learning warrants physical changes within the nervous system. Furthermore learning (long-term potentiation) remains relatively permanent (Blair, Schafe, Bauer, Rodregues, & Ledoux, 2001; Carlson, 2001). Clients generally are unaware of such a time constraint, hence there is the likelihood that it may appear to them that new learning to be a non-smoker, along with fading of the old learning, will never take place. Thus learning to quit probably seems difficult due to unrealistic expectations. However, it is possible that low self-efficacy (Bandura, 1977) in relation to quitting may be positively reframed due to empowerment through the knowledge that while fighting a feeling may be counterproductive, acceptance of the feeling may enable resources to be directed towards a positive outcome. Moreover, the knowledge that learning and hence learning to be a non-smoker takes time may remove or ameliorate a negative expectation.

Memory Storage

Many clients profess mixed feelings in relation to smoking. That is, they feel that they want to smoke and quit at the same time. They are unable to understand why they keep smoking. Many indicate that it is due to addiction and stress relief. To deal with the memory aspect, clients are introduced to the state-dependent process (Bower, Monteiro, & Gilligan, 1978): That is, information is stored according to mood or situation. It is apparent that, at the conscious level, smokers are aware that cigarettes are life threatening, they

smell and taste unpleasant, they rob smokers of vitality, and have little that is positive to offer. Yet deep down, at some unconscious level, smokers apparently feel that smoking is positive — otherwise they wouldn't smoke (addiction will be dealt with later). Without this knowledge it could be difficult to understand the compulsion to smoke, or how easy it is to quit. In essence, memories of cigarette smoking are most likely stored as positives. Cigarette companies certainly promote this aspect of smoking. Thus it is probable that smokers commence the habit for reasons that appear positive during and for some time following the learning phase. This learning is likely to be implicit, that is, without conscious evaluation, and it will probably remain so unless explicitly addressed. This may be, to some extent, explained below.

Amygdala

In relation to implicit/explicit learning, LeDoux (1994, 2000) has shown that there are two processes involved. A stimulus arriving at the thalamus is relayed through two systems. The faster and less accurate is direct to the amygdala and hippocampus, whereby the significance of an event is quickly assessed due to its immediate salience, affording respondent persons (clients) the ability and propensity to react instantly to the stimulus. In many instances, this may be life saving. However, in some circumstances it could lead to long-term negative outcomes due to people's failure to consider consequences. The slower process which engages the cortex and the hippocampus potentially leads to a more reasoned and detailed message being sent to the amygdala, whereby the person is then able to make a more informed decision and as a consequence take seemingly appropriate action. The shorter process is said to be beneath the level of consciousness, whereby reasons for a reaction will not be known (Kihlstrom, 1987). The longer process may facilitate a reasoned action, or explain a previous unconscious reaction. Thus in most instances, only the end product of an action or thought will be known (Kihlstrom, 1987).

It appears that having knowledge of the above facts could empower clients to exercise greater mental control than they might otherwise do. Ostensibly, the knowledge would then enable clients to override the immediate re-act response and instead take a deliberate and reasoned course of action. It follows that the reasoned action would, in many instances, lead to a more positive outcome than an emotional and possibly defensive reaction previously learned unconsciously. In essence, by switching on the cortex (the magic switch) clients are able to reprogram memory such that thoughts and behaviours may be altered (Greenberg, 2002).

Everyday events suggest that many people do not turn on the thinking part of the brain. They tend to react and or let fly with their emotions, often to the detriment of themselves and/or the nearest person, often a family member. There is no immediate relevant feedback nexus to allow experiential learning to occur. Hence negative or detrimental behaviour may be repeated and negative outcomes might not become evident for years.

Through a composite of the above knowledge clients can learn to appreciate the importance of admitting feelings, and consequently make attempts to understand propensities, rather than look for excuses or seek to apportion blame. Furthermore, by instructing themselves to stop and think of circumstances and consequences before acting, clients may facilitate positive outcomes. One such outcome could be smoking cessation. The process is not difficult, and it enables clients to prevent the escalation of problems, as well as to solve solvable problems. However, in addition to having such knowledge, learning physiology informs us that time and repeated practice is warranted if clients are to alter an underlying default and engage their active thinking as a matter of course (Stahl, 2000).

Addiction and Stress

Many clients claim to be addicted to smoking. This being so, we might ask why people take up smoking again after successfully quitting for many years. Or why it is that they have limited problems when deprived of smoking for many hours (on an aircraft flight of some hours' duration) while compulsive feelings surface, due to an expectation of smoking, sometime during disembarking process (Dols, van den Hout, Kindt, & Willems, 2002). Moreover, stressful events or circumstance are claimed as reasons for relapses by many clients. This could be an example of unconscious (faulty) learning through memory storage, without prior and adequate analysis of the facts. Clients then react in an automatic manner based on the inappropriate memories. As a counter measure, the following papers are shown to, and discussed with, clients so that they may have the opportunity to consolidate more realistic memories: "The Urge to Smoke Depends on the Expectation of Smoking" (Dols et al., 2002); "Does Cigarette Smoking Cause Stress?" (Parrott, 1999); "Smoking Cessation Leads to Reduced Stress, But Why?" (Parrott, 1995); and "Cigarette Smoking, Psychological Stress, and Cardiovascular Arousal" (Byrne, 2000).

In the absence of absolutes, the above theory affords a practitioner with some tools that do not appear to have been used extensively in quit smoking

modalities. Justification for using the above theory would need to be based on some form of positive feedback, either through clinical or formal research. The theoretical constructs suggested do not appear to breach any ethical guidelines, nor do they appear to harm clients in any way. Furthermore, presentation of theory while encouraging clients to choose whatever is deemed helpful may enable them to enhance self-efficacy and strengthen resolve. Rappaport (1985) reasons that empowerment can only be taken (seized), not given. Thus, the hypnotic script which follows represents an attempt at enabling empowerment through dissemination of appropriate knowledge. Moreover, the knowledge base has the potential to help clients see that giving up smoking is easy! It just appears difficult because change takes time and prior learning will remain in memory for a considerable amount of time. New learning will not erase the old. Rather it may, through the process of reinforcement, build stronger and more easily accessible pathways for neuronal information to flow.

Clients are provided with the following *hypothetical* situations as a means of perceiving an easy concept or behaviour as difficult.

Please take hold of this rope and pull this one cubic metre of concrete up an incline.

Clients say they would not even make an attempt because it would be too hard, actually impossible.

Clients are then asked to take hold of a light fishing line which is attached to a box of household tissues and to pull the tissue up the same incline. *Easy, they say, sure I will do it!* (The tissue box has a lightweight slide plate attached underneath to prevent wear which would cause the box to disintegrate.)

Clients are then asked if they would pull the tissues to a suburb five kilometres away. *What about 10 kilometres, Darwin to Alice Springs, Darwin to Adelaide?* It becomes apparent that something that is easy appears difficult, or even impossible, if it is likely to take an extended period of time, or if the time period is unknown.

Hypnosis in the context of this paper is treated as a form of communication, which is premised on four behaviour-determining factors (Barber, 2000) — social obligation, the therapist's skill, the effectiveness of the induction procedure, and the depth of meaning. The following script addresses social obligations from the perspective of the client as a family member or, if this is not evident, for hedonic reasons. The therapist's skills are concentrated on the facilitation of client empowerment through the integration of knowledge. The induction procedure at face value may appear to be informal, ostensibly

relying on the client to relax into his or her preferred state. There may be a hint of resistance in skeptical clients. Finally, to obtain suggestive strength and creativity, the process focuses on the client's new-found knowledge and thus ability and confidence to resolve pertinent issues.

The script is generally generic, although it also draws on clients' proffered specific reasons for wanting to quit. The script relies heavily on empowerment through clients' new-found knowledge of mental control processes. Indisputable constructs such as mind-body interactions are then introduced, along with binds which facilitate relaxation and cooperation without there appearing to be any direction provided. That is, the client is free to, and is encouraged to, pursue whatever is believed to be useful. Towards the conclusion, three credible reasons for quitting are offered in the form of a double bind. Clients are free to decide if one, two, or even all three have relevance to their quitting; that is, in addition to whatever motives they are comfortable with.

The above formulae are not intended to stand independent of established quit-smoking methodology. Instead, it is hoped that the addition of salient knowledge will, as Rogers (1963) suggests, enable clients to solve their own problems. The script, designed for a group induction, now follows.

SMOKING CESSATION HYPNOSIS INDUCTION

Some of you are probably wondering whether you can be hypnotised. The answer is yes you can. Although for each of you, the experience may differ. That is, some of you will remember all of what happens, some will remember nothing and others will remember some aspects and some of you may feel that hypnosis has not occurred.

Let us consider some questions you might have: How will you know if you are hypnotised? It doesn't matter. What does it feel like to be hypnotised? Each person may have a different experience. Will I be unconscious? No! However, it is interesting that a person having a medical procedure with hypnosis instead of an anaesthetic is able to talk with the surgeon throughout the process. There is no conscious awareness of pain, yet the person is fully conscious. This would indicate that hypnosis enables you to alter certain sensations.

When you involve yourself in the hypnotic process, you are likely to be receptive to information supplied to you. For this reason, while you are in a hypnotic state, you will be asked to integrate what you have learned consciously with your unconscious. Any other information presented to you will be with your permission, while you are in a hypnotic state. Such information will be of two types. The first will be a story about bodily functions that you will already be aware of, and the second will be in relation

to you giving up smoking. Comments made by me at this stage will be to do with taste, determination, and desire. Thus the entire process will be permissive. That is, you will not be told to do anything. Rather, you will be given suggestions that parallel your conscious thoughts. You will also have freedom of choice, so that whatever you do it will be entirely your decision, not mine.

Essentially you are the ones who will be free of smoking, and it will be you who deserves the credit for your success. The hypnotic process is simply a process which you have in the past used yourself without knowing how. On this occasion, you will be helped to arrive at the hypnotic state. Please think of a time when you have read a page from a book without recalling what you have read, or when you have driven somewhere without being aware that you have passed a given landmark. When this has occurred, you will most likely have been in a trance state although you will have, at the time, also attended to your safety; that is, you will have been in charge during the process.

If there is anyone who has, or thinks they have, had a nasty experience some time in the past, or has something that they might not have dealt with, please be assured that you will be professionally looked after by me, whereby I will help you to deal with your situation confidentially. Are there any questions in this respect?

You will have been asked previously to ensure that you are not wearing contact lenses. Please ensure that you are not, unless you have the type that you are able to wear while you sleep.

I now need permission to touch you, although I might not actually do so. Then with your permission, I may touch both of your arms, in the vicinity of the wrist area. As well I may touch your thumb and two fingers of one hand. You can stay relaxed about such appropriate touch. Thank you!

[Repetition to be freely embedded within the script.]

Now, in a moment I am going to ask you to relax and let yourself think about or focus on something that you would enjoy, like a holiday. That's right, just relax; you don't need to make an effort to listen to anything that I say. It doesn't matter because your unconscious mind will hear every thing that I say. I am just going to talk about a whole lot of things. There is no need to respond to anything I say, unless I ask you to do so.

You can let yourself feel just as relaxed as you would like. I am not sure, though, what relaxation really is. There are times when you can feel energetic and yet relaxed. There may be other times when you just lie back and enjoy your favourite thoughts and other times when you actually take part in activities. These times might be past experiences, or they could be things you are looking forward to. It doesn't matter, all that matters is what you feel. You can feel relaxed and comfortable, or energised and comfortable. I wonder if relaxation is simply cooperation where all of the muscles work

smoothly so that you can move almost without effort. It is as though you are just so coordinated that whatever you do is easy; walking is like floating, running is like flying. You just seem to float along, everything appears easy.

Feeling relaxed may be the same as feeling comfortable. Like being cool when it is hot and like being warm when it is cold. I wonder what these two things are really like, is warm the same as cool — are the feelings actually the same? Are they the comfortable and comforting end results of two experiences that simply amount to comfort? You can remember the comfort and enjoyment of these feelings and yet what is it that you feel in the here and now? You might notice your hand. It feels comfortable. It is just right. Can you feel it or is it just so comfortable that you can't really feel it at all? Maybe you are aware though because you can feel your hand touching something. That slight feeling adds to your comfort, because it lets you know that you are comfortable, safe, and relaxed. You can also feel safe when you are unaware of parts of yourself, probably because your brain knows those parts are safe and because the brain likes you to be safe. Your brain lets you know it feels good when parts of you are so comfortable that you feel little or nothing as well as feeling good when you feel just right. Relaxation, excitement, energy, confidence all feel good; and while you are feeling relaxed and safe you might also experience a range of other positive feelings. You probably feel confident and determined. All the while, you know that your unconscious mind is, and will keep, looking after you, while you continue to do what is necessary.

You can enjoy even more relaxation and comfort as well as determination and confidence; yet there is no rush, the experience will probably happen (not yet: not until I ask you to) after you open your eyes and close them again. That's right! You can open your eyes now ... and close them again ... and just notice the confidence, the positive feeling. It might be like a surge of relaxation and comfort, or maybe a slower, deliberate and strong, feeling that sweeps over you. It is not important how it happens, just notice how it feels to you. That's right ... confidence, safety, relaxation and determination: a feeling of quiet and respectful confidence.

You might like to let yourself notice abilities and strengths you were unaware of. Like your breathing. All of this is controlled by your brain, your unconscious mind. Your brain is in charge of a sophisticated chemical process (a chemical factory) — your lungs. They take oxygen from the air mixture, separate out the nitrogen and other gases, which enables you to feel invigorated, and provide pleasure and relaxation each time you breathe in. It is as though you breathe in relaxation and you breathe out stress and tension; yes, in with relaxation and out with stress and tension. You take in positives and let out the negatives. This is a filtering process and relaxation continues.

You have probably noticed that parts of you are relaxed, I don't know which parts, it could be your hands, feet, or any other parts, or maybe all of you. It doesn't matter

because the relaxation can continue to spread. I am not sure how far it has gone, but you will find that it has spread or will spread along the arms, the legs, through the torso (main frame of body), the neck, and the head. That's right; the relaxation can continue to spread. In a little while, I am going to say the word "now." When I do, you will notice almost like a rush, a fantastic feeling of relaxation confidence and determination. A quiet respectful confidence. "Now."

You know that you have other physiological filters, as well as your lungs. You have a gastrointestinal tract. That's another chemical factory that separates out fluid and nutrients that your body requires. What is not required is later excreted. It is interesting that this complex chemical process happens unconsciously, with your brain in charge of the process. Your kidneys are also sophisticated chemical organs that work under the direction of your brain and nervous system. All of this is going on, yet you do not have to concern yourself about any of it. The process is unconscious, yet your brain is in charge.

You also know that your brain has its own filter. That's right, a mental filter. Your mental filter works for you without your awareness, yet it might not always do what is best for you. This could be when, and if, you have unconsciously learned something that doesn't work for you. It is useful that you can change your mental filter; it can happen quite quickly, all you need to do is to let it happen. You may notice or feel that your problems are all leaving, just floating away. All of the positive thoughts stay with you; but the negatives? Well you cannot find them, because they have gone! You might even like to push them out, as though they are things that you can pound into environmentally friendly particles for the breeze to blow away. Or you might prefer to simply lose the key that tells you where negative memories were stored. It really doesn't matter because the negatives have gone, although it is possible that you need a little more time to finally reset your filter. By then, all negatives will have dissolved, and all positive memories of cigarettes will have been converted to negatives and they will be lost.

You may, if you wish, remember that you can use a positive to eliminate a negative. This means that you can use your positive mental strength to remind yourself of just how negative stinking, dangerous, expensive, and life sapping tobacco smoking really is. That's right, just let unhelpful memories leave forever, out through the filter, and then allow the filter to reset itself so that the negatives are locked out. At the same time, the filter can be reset to let in only positives which can then be locked in. Then, what you think and do in the future, maybe even starting right now, will be positive. That's right! Just as you can replace a faulty air-conditioning filter or car oil filter, you can change your mental filter. Just let it happen. Turning on the magic switch in the brain can also help you lock in and cement the changes in place. Then your unconscious mind will do what you want consciously to be; that is, a non-smoker, a person who is free of cigarettes.

You can at the same time be a person who is positive, considerate, respectful and self-

respecting. All of this can be done unconsciously, so that at the conscious level you can focus on what you enjoy and what you would like to learn or change. Your unconscious mind keeps looking after you. It will now be able to look after you, even more positively than it has in the past. Your unconscious mind is never wrong; it keeps trying to serve you better. Yes, you can let it help you through your positive mental filter. That is, now that your unconscious mind has reset or is still resetting the filters to let in only positive and helpful information. It has probably reset already, although you might like to take a few minutes later to let the process complete itself. At the same time, further letting out any negatives that have been in storage. This then allows the filters to let in and keep in positives, as well as let out and lock out negatives. By letting your unconscious mind reset its filter, you will have enhanced, or will be enhancing, your ability to achieve your goals.

Now that you have made the move, you can be free of cigarettes, a non-smoker. Let the process of change continue so that your conscious and unconscious minds work together in your best interests. Soon you can take as much time as you need for this process to complete itself.

Allow a minute or so.

You might also choose to allow yourself to integrate (take in to your unconscious) the magic switch process and all of the things that we have talked about and that you have agreed are in your best interests. Let yourself turn on the switch, when it is in your interest to do so, and tell yourself that you do not smoke. You might also let your unconscious mind discover what enables you to be a non-smoker, to be smoke free. Is it that cigarettes smell and taste like rotten garbage, or is it that you have a strong and determined almost rigid determination to not smoke, or is it that you have no desire at all and prefer to be smoke free? It could be all three. Which of those is giving you the strength, is it one or two or all three?

Please take as much time over the next three, four, or five minutes to let your unconscious mind work through all that it needs to do to ensure your success as a non-smoker. A permanent non-smoker. You might even like to just let yourself see ahead a week, maybe two weeks, then a month, then a year or many years and imagine yourself as a happy enthusiastic healthy non-smoker. You will probably know deep down that you could not and will not ever smoke again. Yes, you can remain a non-smoker. When you have taken as much of the three, four, or five minutes as you need, then you can open your eyes, become wide awake, alert, and confident, respectful, self-respecting, and a permanent non-smoker.

The normal review and follow-up procedures are carried out individually, or with the group.

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RAINBOW

James M. Auld

Dental Surgeon

People often ask for scripts that they can use in group hypnosis sessions, especially in training sessions with health practitioners who are learning hypnosis in order to utilise it in their practices. Note that the words that are in bold type are meant to be emphasised, so that they stand out in some way from the rest of the words that surround them. This emphasis may be achieved by conventional volume changes, or more subtly by marking out the words or phrases by pauses, or by a change in pace or voice tone. The following can be used by students as an exercise in communicating the hypnotic experience through voice control as well as imaginal involvement. It is also a good in(tro)duction for subjects to experience indirect techniques. It could also be used with patients/clients who need to get in touch with their inner strengths and past successes to help them through a present difficult period.

*Many of you have experience of trance and many of you have trance experience, but I wonder whether you have allowed your experience **with** trance to affect your experience of trance. Do we learn to experience trance through the conscious mind or through the unconscious mind? Is the conscious mind the observer while the unconscious participates in the process, or is the unconscious mind the silent watcher while the conscious mind goes through the trance-formation? You know you can think consciously, but do you **really know** how much thinking goes on unconsciously, until you **assign a task to your unconscious mind** and wake to find it done?*

*There are so many things in life that seem real, and yet exist only in our minds, or **in the transient reality** of the moment. We feel anxiety, depression, anger, hope, love, but these are all internal experiences. No one can look at you and say “you are frustrated, you are depressed”, it is only by interpreting your behaviour that that assumption can be made. You cannot catch anger, or anxiety, or pain, from someone else. You can’t distil it and bottle it, although you can bottle it up. You can’t photograph it. You can’t describe it, except in emotional terms.*

You can think of many things in our reality which are somewhat similar, but there are certain emotional memories that are common to us all.

You may have **conscious understandings** about these **memories** that are **intellectual**, and **unconscious understandings** about these **memories** which are **emotional**. And the **conscious understandings** about these **memories** which you have **intellectually** are different from the **unconscious understandings** about these **memories** you have **emotionally**. That doesn't mean that you can't have **unconscious understandings** which are **intellectual** or **conscious understandings** which are **emotional**.

But you can probably **understand** much better if you **just let yourself float** along with that sea of scenes which you are able to see when you **really let go**. You can remember many things. Birds riding invisible currents of air and crying out to each other, sparkling reflections on water, the sounds of wavelets lapping at the rocks, the smell of the salty air — a fine sunny day, calm and clear, then seeing a storm appearing on the horizon, the clouds building **deeper** and **deeper**, the **light** getting **darker** and darker, shadows **becoming deeper** and the distant view **becoming more and more difficult to see**. You **anticipate the changes**, the oncoming wind and rain, and hasten to secure everything around you, **to seek shelter** and protection. And you begin to get the smell of the storm, wafts of cold damp air, heavy with the scent of wet earth and foliage.

As you **relax** and look out **in your place of safety**, there is a flicker of lightning, followed after a little while by the crashing roll of thunder. Birds disappear as they fly to **safety**, stock seek the **protection** of trees, and domestic animals look for their **hiding places**. And you can **feel very comfortable in your secure place**, knowing that all your preparations have been adequately made.

And then the wind comes, howling in from under the clouds with a malevolence which **fully justifies your preparations**, rattling the windows, whipping up waves on the water and dust on the land, and flinging loose articles **carelessly** right and **left**, where they can be **caught** in the maelstrom. Lightning flares again and again, and thunder explodes with ever-increasing intensity. The rain follows, slanting down with a **demonic fury**, pushing against everything in its way, finding the smallest cracks into which it can penetrate, saturating everything in its path, and forcing down to the ground anything without the strength to resist it.

Then, as the storm front passes, the rain begins to **ease and relax**, although the job it started is **still not finished**. It goes on, wetting everything thoroughly, **washing away** the dirt and grime, **cleansing** all the paths and lanes, **flushing away** accumulated detritus, down drains and creeks, **replenishing** ponds and springs, where it becomes a valuable resource for all the little creatures which live there.

And everything begins to look cleaner, brighter.

*The storm continues to diminish, and soon you **begin to experience a lightness** in one way or another, on one side or the other, where you can **point out** more details, and it **gradually spreads** to **encompass the whole sky, lighting up the arm** of the river, **lessening** the gloom, the depth of **shadows, lightening** the colours. Finally, somewhere, the sun **rises** through the storm, pointing an **arm of light** onto ponderous, dazzling white clouds, a glistening landscape. The sound of the birds comes alive again, plants and grass and gardens shine, the air smells fresh and clean, and the whole world seems renewed. And with that **light** beam, you have **in sight** — the necessary **storm receding** as **all the good things, that come after, begin to appear.***

*Those clouds really did have a silver lining, only **you couldn't see it from inside** the storm. Who would have thought that clouds which **looked so black** a short time ago could be **so clean and fluffy** from the other side? You were **too concerned** beforehand with the **impending crisis** and what you could do about it, but when **you can see through the gloom** into the light once it has passed, you have the luxury of being able to **sit back and reflect** on again passing through a time of difficulty and succeeding.*

*But it is not finished yet. As the clouds clear further away and the sun becomes stronger, you are treated to one of the most beautiful and delicate displays in the natural universe. Part of your mind may tell you it is the multiple refractions of sunlight within millions of raindrops at the critical angle of 22 degrees between your line of vision and the source of light, but another part of your mind tells you it is a rainbow, and your heart marvels at its perfection. **You can reflect** on its **beauty** and symmetry, and you can **realise that you can only see this beauty after the storm has passed.***

We have so many references to rainbows in our language: the pot of gold at the end of the rainbow, going over the rainbow, colours of the rainbow. Yet no one has ever touched a rainbow. No one has ever captured the tiniest part of a rainbow. No one has been able to bottle a rainbow. And still they exist. So is a rainbow real, or imagined? It is not imagined, because we share the experience. Yet it is not real in one sense, because even when we reach the point where the rainbow appeared to touch the ground, it is no longer there, having moved on somewhere else.

And maybe your life seems a little like this — preparing for and braving the storms and tempests, following your rainbow, and never really feeling that you have arrived, always being tempted onwards like the siren song of mermaids for lonely sailors, always looking for your pot of gold.

*Yet **you can follow your rainbow.** The attraction of pure beauty, **in whatever form it presents,** can help to **stimulate you to achieve your possibilities,***

to **strive for continuing self-realisation**. You can never be **IN** a rainbow, you can only look at it from a distance, and the pot of gold is not to touch our rainbow, but to follow and admire from that distance, never reaching the end of the road.

But **just now**, you can **reach out** in your mind and **touch your rainbow** — stretch out your arms and caress its perfect curve, absorbing that perfection, the smoothness, feeling the colours, the texture of the bow, seeing its softness, and **knowing** that this is a very **special experience** for you to carry with you always, to **use whenever you are in need of peace and comfort**, in the things you do.

You can **remember** that you can only **see your rainbow** when you turn your back to the light, **looking back toward the past storm**. You can **see those dark clouds** of your storm **receding** into the distance, the cleansing rain releasing and **washing away frustration, depression, negative thoughts**. The beauty of the rainbow is like the **clarity of thought** that you can have when your conscious and unconscious minds are in **harmony** and focused on the work you are doing, so that **your mind is clear**. Any rainbow is formed from tiny pieces of very ordinary matter, but **you can only see it when you look at things in just the right way**, at just the right distance, and that **sometimes you have to turn your back** on the light to do that. That beauty is hidden until you **learn to look at things** in just the right way so that you can **see what is really there** and unlock the hidden secrets.

Whenever you are faced with a storm, you can **remember this experience** of finding your rainbow again, and know you will come through it well using **all the inner strength you have**, but don't know that you have, and it's not important for you to know it as long as you don't "no" it. That feeling of peace and calm can continue with you for as long as is needed for you at this time, and can be realised again whenever you really need it.

[Give amnesia suggestions, if appropriate for the clients/students.]

Before you come back,
 I don't know a lot about your other strengths and positive abilities
 but these are some of the things you can
 choose to try to forget about remembering ...
 if that is important to your comfort ...
 or even if that is only indirectly important ...
 or maybe just one of the things you are willing to accept as important ...
 if you listen carefully for exactly what you want to hear...
 while thinking about something else...
 just as comfortable ...

only a little different.

And then come on back ...

*And you can take all the time that you need
in the time that you have.*

SKIPPING OUT ON THE DENTIST

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The following is a short script that can be used with clients who are fearful of the dentist because of unpleasant experiences they had had as a child. The first part of the script utilises the Ericksonian technique of “My Friend John,” while the main part makes use of both direct and indirect hypnotic language.

Let me tell you about a health professional that I know. Susan is a 45-year-old female who had had a lot trouble with her teeth when she was young. Susan remembers the visit to the dentist being arduous, painful and depressing. She recalls that the sound of the drill was like a jackhammer on the road and she commented that the feel of the drill on her teeth, mouth, jaw, neck, and shoulders was heavy, pressing, and very uncomfortable.

Susan also remembers that injections were extremely painful and resulted in her mouth feeling numb for many hours and that the children at school would laugh at her face because only half of it would move when she talked. She also remembered that she could not eat anything for a long time.

As a young adult, Susan had learned about mental thought control techniques and would use dissociation while she was sitting in the dental chair and would image herself climbing outside the dental building and exploring the tops of buildings and the neighbourhood. Then before she went to the dentist she told herself, over and over, to relax and gave herself instructions about not feeling pain.

Many years later, when she had learned about hypnosis, she told herself to go into a trance as soon as she sat in the dentist’s chair. She managed to stay deep in a trance while the dentist talked to her, and she was able to stem the flow of blood when her wisdom tooth was removed and to prevent a dry socket by listening carefully to what the dentist was saying about what was happening in her mouth; and the same time she would remain calm and relaxed and immediately take herself away to walk in her garden, or on the beach, or in the mountains — anywhere but the dentist room.

Susan complained that she was often so relaxed that the dentist would ask her if she was all right. She explained to him that she was using self hypnosis and then suggested to him that he might want to learn more about self-hypnosis. And now Susan would like to say something to you:

“Imagine that you are so relaxed, as you lean back into the dental chair, that it is hard to keep your eyes open and you feel relieved when the dentist commences his work, so that you can get on with your mental adventures. One of the good things about being in a dental chair is that it is so firm, comfortable, and secure that it supports your body totally and this releases your conscious and unconscious minds from having to think about everyday matters. There is no need to keep your eyes open, unless you want to look at what is on the ceiling, or outside the window, because you can do both — you know, you can look with your eyes, seeing, or unseeing, at what is there above you inside the room, or outside the room, while your unconscious mind takes you on one of those delightful daydreams/fantasies that it is inclined to do.

“Now remember, in all these daydreams and fantasies you will be perfectly safe, because you can always do things in daydreams that you are not necessarily able to do in real, everyday life. After this session, you will know exactly what to do to automatically differentiate between what is daydreaming and what is reality — to stay safe, while you feel more able to do many things that you have always wanted to do — things that you are capable of doing and that also match your value system.

“I once knew a woman who liked to escape from the dentist room by imagining that she could climb outside the window and go walking across the roofs of the neighbouring buildings, and while she was up there she would observe what was going on in the streets below and the countryside a little further away, if the procedure became more uncomfortable at any time. She had heard that this ability had something to do with her ability to both dissociate and then become absorbed into new activities, ones that were more pleasant to her than being in the dental surgery worrying about what was happening in her mouth.

“Thus she would fully associate into the daydream and experience what was happening, visually, audibly, and kinaesthetically and when necessary her olfactory and gustatory senses would activate, because there was a bakery on the other side of the road where they sold her favourite apple and cream pastries, and meringue tarts that had real lemon inside them. That taste was so sharp that sometimes it made her eyes water, and if ever her eyes started to water in the dentist chair she would immediately imagine visiting the bakery and having a tasting session — a little bit of this, a little bit of that and oh yum, it was good to be out and about, knowing that if she looked after her teeth she could continue to eat all her favourite foods.

“I heard from another male client that he would imagine himself lying down on a flat

roof and just looking up at the clouds in the sky (as he did when he was a child) and he would make shapes out of the clouds and give them all names of animals or anything at all that he liked ... to do ... this ... because it was fun; and now as an adult, there was little time to do such things in reality, because he led such a busy life. It meant that he did not feel trapped in the dentist chair. Rather, he felt an indescribable feeling of freedom — this, he felt sure, was one positive by-product of being fantasy prone.

“Interestingly enough, there was another client who must have been one of Erickson’s great-great-grandchildren because he was really good at incorporating all the noises in the dentist surgery into different sights and feelings that overall were positive for him; so when he heard the drilling noise, depending on its pitch, he would imagine himself taking off in a small, but sturdy, light aircraft and flying over the fields and out over a beautiful wide expanse of clear, blue water to a small, green Pacific island where he would explore different areas of the island. Of course, he always came back safely when the dentist had finished the work.

“If the drilling sound was deep and made vibrations throughout his body, he took the opportunity to think of doing some major excavations on the pile of rubbish that had been accumulating for months, or even years, in his unconscious. And he would telephone for a 100 tonne truck — yes that is a lot of rubbish is it not (unlike the little tiny amount of rubbish in his pearly whites) — to take this now unwanted and unneeded junk away and to dispose of it in an environmentally friendly way. He would always feel so much cleaner and clearer and freer after he had been to the dentist, and there would be a new spring in his step as he went on with his life’s activities.

“Now you can do anything you like with your conscious and unconscious minds. While you sit or lie in the dentist chair; just tell your dentist to wake you up when he has finished, and not before, unless he needs your attention. Make sure that he knows that you are quite safe when you do not respond to procedures that he thinks might be painful, by asking you in a quiet voice to raise a finger on one of your hands, whichever one feels the freest, if you are still physically comfortable and functioning normally. After all, dentists are just people who miss out on some of the fun that they do not know you are having in your mind.”

INDIRECT HYPNOSIS WITH METAPHOR

James M. Auld
Dental Surgeon

The following text is provided to illustrate the construction of embedded metaphors. It would need to be set within the appropriate problem identification and assessment processes and history gathering, and followed by suitable termination of the hypnotic state and normal debriefing procedures. The theme is about being creative and resourceful with a client who has chronic pain.

First Metaphor

*My associate and I both enjoy photography, but we both know **you can see things in very different ways**. She has a photo at our office which shows a deserted beach with an old iron shipwreck in the breakers — and **something else** which makes it memorable.*

*I asked how she managed to get such a photo, and she told me she had been on holiday at the coast, enjoying taking photographs of this thing and that thing, and always seemed to end up on the beach in the afternoon. She was attracted by the long expanse of sand and the mystique of the old shipwreck, but **there was something lacking**, some visual necessity to complete the picture. And this went on for several days, always with the certainty that there was a picture to be recorded, but **the feeling that it was not right** as it appeared.*

And when I asked her how she found the image she finally recorded, she said: “I will tell you, but first I want to ask your assistance with a problem.”

Second Metaphor

“There is a patient I have seen several times recently for chronic pain, but have been unable to find the source of the pain or to give any relief. I am very worried about him, and concerned that I am unable to help him. What should I do?”

I know her well enough not to have to ask about the tests which she would have already performed as part of her diagnosis, so I said: **“You probably have all the information you really need, but you are not able to see it yet.** Why don't you think about it carefully over the weekend and see what you find? She agreed, and said she was going to model a clay head of this patient, that she would do it this weekend and think about his problem while she worked.

On the Sunday, I received a phone call in the evening. She said: “I started on the head this morning at 20 past 9, and when I stopped for a break my clock said it was 6 pm. I checked the other clocks in the house, and they all agreed — it was 6 pm. I looked outside and the sun was setting. Where did the day go?

I asked if the sculpture was finished, and she replied: “I have been quite creative, but I feel **there is still something missing**, I can see places where the proportions seem slightly out. I will bring it in tomorrow and show it to you.”

The next morning I viewed the creation of the previous day, and I said to her: **“Your unconscious knows a lot more than you do.”**

(The following is a version of Milton Erickson's “early learning set induction” which is easily learned and useful in many situations. It is given here as a suggestion to lead into a review of life experiences and learning — looking back — recovering resources from past experience specific to the patient and relating to the patient in the present with the particular presenting problem. Continue to do this for as long as it seems necessary to adequately cover the experiences of the past, the needs of the present and the expectancies of the future.)

Third Metaphor

“When you think back to the time you started primary school, you had to learn the letters of the alphabet and that seemed a very difficult task. Do you dot the ‘e’ and the ‘t’ and cross the ‘i,’ and which side does the loop go on a ‘b’ and a ‘d’ and where does the tail go on a ‘q’? And yet all the time you were forming mental images of the letters, without knowing you were forming images. And then there is script and print — all those images — and you can remember all those images. In high school, you continued to form images, of ever greater complexity based on your previous learning ...”

*And all those images, all those memories, all those resources and abilities are permanently stored in your unconscious mind. You can **really begin** to use all those resources you have forgotten learning so long ago, if you **just let it happen**. It may not be right now, but **sometime soon** before the end of next month, you will **begin to experience** the full power of your unconscious learnings **starting to work** for you when you really need them. And isn't it nice to know that you really have that power?*

Back to Second Metaphor

*She was totally absorbed in the head during all of this, and she said, “Now I know what I have been missing — this man’s face is asymmetric; there is more muscle development on one side — he is experiencing muscle pain which is referred to different areas of his face!” I agreed this was probably so and pointed out again **that you can begin to see the whole picture when you begin to use all the information you have** — and sometimes you need to be in trance to do that.*

Back to First Metaphor

That prize-winning sculpture is on display in her surgery now, and just outside the door is her photo of the beach. She said: “Now I know why I waited so long for that picture. The beach was beautiful and the old wreck formed a focal point, but the whole was dead — it needed life. The ice-cream van was always there, but I didn’t realise it until I stood in a particular position, and then knew I could include it and the children in such a way that it all appeared to be on the beach. So now you have the old rusting wreck stuck on the sand in the breakers on one side, and the ubiquitous van on the other with the life and colour of the children around it, and the beach leading you off to infinity, framed by the blue of the sea and the sky and the green of the hills.

Suggestions for Amnesia, if Appropriate

*I don’t know a lot about your strengths and positive abilities
but these are some of the things you can
choose to try to forget about remembering ...
if that is important to your comfort
or even if that is only indirectly important ...
or maybe just one of the things you are willing to accept as important
if you listen carefully for exactly what you want to hear ...
while thinking about something else just as comfortable ... only a little different.
And you can take all the time that you need
in the time that you have to come back to your here and now
etc. for reorientation and trance termination.*

It can be a very interesting experience for students of hypnosis to hear this script. It is an innocuous introduction and a “story,” but on the many occasions I have used it in workshops it almost invariably results in amnesia for the third embedded metaphor, the “early learning set.” It is a powerful demonstration of how a significant depth of trance can be induced with a conversational induction, and how readily a significant degree of amnesia can be produced.

**SCIENTIFIC PROGRAM ABSTRACTS OF THE
35TH ANNUAL CONGRESS OF THE
AUSTRALIAN SOCIETY OF HYPNOSIS,
NEW SOUTH WALES, SEPTEMBER 2005**

Keynote Address

Hypnosis: Expect the Unexpected

Michael R. Nash, University of Tennessee, Knoxville
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Explaining the genesis of stable individual differences in hypnotic responding is arguably the most fundamental undertaking of any scientific theory of hypnosis. Expectationists contend that the extent to which an individual responds to hypnosis depends mostly, or even entirely, on self-expectations. On the other hand, aptitude-centred theorists posit that stable individual differences in hypnotic performance reflect the direct and substantial operation of a latent cognitive ability. I discuss these literatures in light of a new study that tracked expectations over time and used a structural equation modelling analysis to test the expectationist and aptitude-centred positions. I conclude that, for the most part, first-time hypnotic subjects must expect the unexpected.

Invited Addresses

Looking for the Fundamental Effects of Hypnosis

Amanda J. Barnier, University of New South Wales, Sydney
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In hypnosis, simple words have a dramatic impact. For hypnotisable individuals, hypnotic suggestions lead to behaviours that are carried out with involuntariness bordering on compulsion and experiences that are believed in with conviction bordering on delusion. But are hypnotic behaviours and experiences created differently from other, non-hypnotic behaviours and experiences? To answer this question, I review research on classic hypnotic phenomena including post-hypnotic suggestion, post-hypnotic amnesia,

hallucinations, and delusions. Based on this research I offer a new account of hypnosis that explains the source of its fundamental effects — surprising ease and surprising reality.

Stress and Trauma: Using Hypnosis to Understand and to Treat

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Post-traumatic stress disorder (PTSD) is the major psychological disorder to arise after exposure to a traumatic event. Many features of PTSD are difficult to understand and study in the clinic. I outline attempts to utilise hypnosis to identify some of the core mechanisms underpinning PTSD. I focus on experimental studies in the hypnosis laboratory that have investigated emotional numbing and suppression of unwanted thoughts. I then turn to the role of hypnosis in treating PTSD, and outline the first properly controlled treatment study that has applied hypnosis to treating PTSD. Finally, future directions for applying hypnosis to the study of PTSD will be explored.

The Lustre of Hypnosis

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Over the last 30 years, there have been significant shifts in the way in which the phenomena and processes of hypnosis have been conceptualised and investigated. These shifts have been influenced by particular individuals and events, both international and Australian, and I first consider the domain and the modern history of hypnosis. I then consider the salient features of competing explanations of the nature and effects of hypnosis, and draw out selected aspects of the theoretical foci, supporting evidence, and empirical questions contained in and raised by those explanations. Finally, I reflect on the scientific themes in the 35th Annual Congress of the Australian Society of Hypnosis, and speculate on the possible future of investigating and using hypnosis.

Papers

The Use of Hypnosis and Suggestion by an Obstetric Anaesthetist

Allan M. Cyna & Marion I. Andrew, Women's and Children's Hospital, Adelaide

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A Comparison of Midwives' Knowledge of and Attitudes to Hypnosis in Hospitals With and Without a Hypnotherapy Service

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We performed a cross-sectional survey of midwives' knowledge of and attitudes to hypnosis in hospitals with (CH) and without (NCH) a clinical hypnotherapy service. A 28-item questionnaire was distributed to a random sample of midwives at the two hospitals. The overall response rate was 118 of 130 midwives (91%). Compared with NCH, CH midwives were more likely to support the use of clinical hypnosis ($p < .001$) and hypnosis as being helpful during childbirth ($p < .001$), and to recommend hypnosis as an analgesic adjunct during childbirth ($p < .001$). CH midwives were also more likely to express an interest in hypnotic techniques being taught during midwifery training. The vast majority of respondents (83%) agreed that positive suggestion techniques should be taught during midwifery training.

Conversation Analysis: A Method for Studying Hypnosis in the Clinical Setting

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Clinicians have much to contribute to the scientific literature on hypnosis, and researchers are encouraging them to do so. Yet researchers and clinicians often have different views on how research should be conducted. Whereas researchers stress the need for systematic rigour, clinicians often state that researchers base their findings on contrived situations that have little to do with real-world clinical practice. To help bridge the methodological gap between clinicians and researchers, this paper demonstrates that conversation analysis is a suitable method for the systematic and rigorous study of naturally occurring hypnosis in the clinical setting.

Memories of Abuse in and out of Hypnosis: Where Are we Now?

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The reliability of memories of abuse, in and out of hypnosis, has been studied in many different ways over the past 20 years. With the rise of litigation against the churches, teaching, health and helping professionals across the world, and an inquiry into the practice of “recovered memory therapy” in Victoria, there is a need for practitioners and researchers in hypnosis to be conversant with the theoretical and research debates about memory which have an impact on this area. I review the literature on memories of abuse and summarise the implications for practitioners and researchers in this field. The necessity for societies such as ASH to educate the public, health professionals, and government bodies on these issues is now more urgent and critical than ever before.

Hypnotic Disruptions of Reading: Investigating Modulation of the Stroop Effect

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Hypnotic suggestions can produce changes in information processing that are accompanied by behavioural and experiential alterations. I investigated the impact of two suggestions on one form of information processing, reading; in particular, hypnotic modulation of the Stroop effect. Before hypnosis, high and low hypnotisable participants performed a waking Stroop task, in which they classified the ink colour of incongruent (word and colour inconsistent) and neutral (word irrelevant to colour) words. During hypnosis, participants received either a colour hallucination and word agnosia suggestion, or an attentional focusing strategy aimed at disrupting semantic processing. Participants were then administered a formal visual test of the suggestion and a hypnotic Stroop task. Findings indicated that the suggestion influenced participants’ experiential but not behavioural processing during hypnotic Stroop. These findings are discussed in terms of hypnotic information processing, as well as relevant strategy enactments in hypnosis.

Hypnosis Decouples Cognitive Control From Conflict Monitoring Processes

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The cognitive and behavioural phenomena associated with hypnosis have long been thought to relate to attentional processes; the neural mechanisms underlying susceptibility to hypnotic induction and the hypnotic condition are poorly understood. We tested the proposal that highly hypnotisable individuals' attentional control is compromised following hypnosis due to a decoupling between conflict monitoring and cognitive control processes of the frontal lobe. Employing event-related fMRI and EEG coherence measures, we compared conflict-related neural activity in the anterior cingulate cortex (ACC) and control-related activity in the lateral frontal cortex (LFC) during Stroop task performance between participants of low and high hypnotic susceptibility, at baseline and after hypnotic induction. The fMRI data revealed that conflict-related ACC activity interacted with hypnosis and hypnotic susceptibility, in that highly susceptible participants displayed increased conflict-related neural activity in the hypnosis condition compared to baseline, as well as with respect to subjects with low susceptibility. Cognitive control-related LFC activity, on the other hand, did not differ between groups and conditions. These data were complemented by a decrease in functional connectivity (EEG gamma band coherence) between frontal midline and left lateral scalp sites in highly susceptible subjects after hypnosis. These results suggest that the hypnotised condition is characterised by a functional dissociation of conflict monitoring and cognitive control processes.

Obstetric Hypnosis: Three Case Studies

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Utilisation of a hypnosis-based strategy in the psychological preparation for the peripartum period is examined in three case studies. Two primips (33 and 34 years) and one multip (34 years) underwent hypnosis sessions during the third trimester of pregnancy. Sessions were audiotaped to enhance practice effects. Hypnotic techniques included post-hypnotic suggestion, time distortion, age progression, glove anaesthesia, and special place imagery. The subjects were surveyed within one month post-delivery. Pre-formulated goals for the hypnosis intervention in the peripartum period were met with subjects

reporting reduced antenatal anxiety, a minimal level of medical intervention, and acceptable labour and postpartum symptom control. Benefits of tailoring hypnotic interventions with the inclusion of spouses/support persons, and the utilisation of out-of-session practice to optimise treatment efficacy are discussed.

The Use of Hypnosis in the Treatment of the Primary Parasomnias: Nightmare, Sleepwalking, and Sleep Terror Disorders

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The results suggest that the effective element(s) in decreasing nightmare frequency were specific hypnotic suggestions to alter the nightmare content. In patients with sleepwalking and sleep terror disorders the effective element in decreasing frequency of events appeared to be the generalised effects of hypnosis. The data support the observations of other authors who have suggested the general lowering of tonic levels due to the anxiolytic effects of relaxation employed during hypnosis is responsible for reducing the incidence of these disorders. In conclusion, hypnosis is a relatively simple, non-invasive, inexpensive, and effective means of treating nightmare, sleepwalking, and sleep terror disorders.

Measuring Hypnotisability: Fact or Fiction?

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Hypnosis is an important therapeutic modality, yet in both clinical and research areas the assessment of levels of hypnotisability have been derived from outcomes rather than from predictors. It was the aim in this study to develop a pencil-and-paper test of the predictors of hypnotisability based upon known correlates. One hundred and twenty-one people completed the QMI, the Gordon scale of imagery control, the AIT (absorption, intellectance, and traditionalism), a modified version of the Creative Imagination Scale (CIS), and a series of questionnaires related to personality variables. The results provide support for the viability of visual imagery ability and control, absorption, and intellectance as predictors of hypnotisability. Support for this finding was strengthened by the convergence of these predictors on the CIS which was self-administered by respondents. Future studies will need to confirm these findings, especially in relation to scores obtained through hypnotic induction.

REVIEWS

Hypnotherapeutic Techniques (2nd ed.)

Arreed Barabasz and John G. Watkins

New York: Brunner-Routledge. 2004. xviii + 490, hardback

Here is it — what most coordinators of hypnosis courses, in professional hypnosis societies and universities around the world, have been looking for. But don't take my word for granted, buy or acquire a copy of this book and see for yourself. No, it is not just for the beginner, it answers a lot of those nagging questions that experienced practitioners might want to check up on from time to time, or to quote to their clients at the right moment.

The book comprises 18 chapters that span the history of hypnosis, hypnotic phenomena, relevant theories, the issues of hypnotisability, and the important issues surrounding placebos, suggestion and the role of the hypnotherapist. The main body of the book effortlessly lays out hypnosis techniques, both introductory and advanced, and then guides the reader through a range of applications that span its use in pain relief, anaesthesia and surgery, childbirth and trauma, dentistry, sports performance, and specialised problems such as smoking and substance abuse. Chapter 17 informs the reader about the magic of using hypnosis with children, although it does not use the term “magic.” The authors have also incorporated three welcome chapters on mind–body interactions and meditation. Just when you think that the good points have all been listed, you find an appendix containing a very useful list of hypnosis societies and journals throughout the world.

Convince me further, you say. All right then. For a start, these authors have actually written a highly informative overview of what the book contains in their preface — an usual occurrence in most books nowadays. They take the time to justify the use of hypnosis is a world where evidenced-based practice rules the economic roost and consequently the health dollar. If you are not going to read the whole book, then ask to buy the Preface, as it may save you, whether as a practitioner or an academic, some frustrating attempts at

explaining the efficacy of hypnosis as a treatment modality. Barabasz and Watkins cite “rigorously controlled studies” that show that “hypnosis is not just effective but also superior to a number of standard treatment procedures” (p. vii). It is “cost effective” (p. viii) and it is not culture bound.

Your next question no doubt would be to ask: “But what does this book on hypnosis cover that others do not?” That answer is easy, as it brings together in one volume that which we, as teachers of hypnosis, have had to employ many books and teaching manuals to coordinate in the past. While the teaching material is well grounded in theory and research, it is written in a way that is comfortable for beginners in hypnotherapy to read and comprehend.

Does it have the same old boring stuff on theory, you ask? Well let us say that nothing about the study of hypnosis is boring, and while other writers may not have pitched their level of comprehension at the non-academic practitioner, Barabasz and Watkins have managed to respect the high intelligence levels of health professionals and still write in a way that makes the reader want to continue, and they demonstrate how recent breakthroughs in theory have shed new light on what actually happens in hypnosis. What is amazing is that they cover so many theories in just one chapter.

Even Patrick McCarthy from New Zealand rates his own mention: The McCarthy Method of childbirth, which some of you have had the opportunity to learn about in workshops with Patrick, is described on pages 276–284. Harry Stanton’s contributions to understanding test anxiety are referenced and the works of outstanding Australian academics, such as Peter Sheehan and Kevin McConkey, and the late Campbell Perry, are acknowledged for their important role in hypnosis research.

So you want me to give some constructive feedback now as well? First then, while the photographs that are included demonstrate important hypnotic phenomena, they are undoubtedly outdated and look historical — future editions could change their look through creative digitisation processes without adding more costs to the production and thus to the purchaser. Second, hypnosis is practised throughout Asia and Africa and research from those two continents could be cited, as well as including trance techniques (that appear to be uniquely culture based but in fact have an underlying universal mechanism that can be applied in other cultures) which would enrich further editions of this valuable resource.

The hardcover edition is mandatory for students and interns, as this book will be treated as the well consulted bible on hypnosis, while a health

professional weaves his/her way through the maze of what to do and what not to do in hypnosis practice.

KATHRYN M. GOW

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Memory: A Guide For Professionals

Alan Parkin

Chichester, England: John Wiley and Sons. 2000. 174. \$US50, paperback

Memory: A Guide for Professionals is written by Alan Parkin, who before his death in 1999 was a professor of experimental psychology at the University of Sussex, who is an internationally recognised expert on memory and its disorders. Parkin's latest book on memory contains seven chapters. Chapter 1 starts with the "basic facts," a basic introduction to memory covering psychological and anatomical distinctions between the different types of memory and the evidence for those distinctions. In Chapter 2, Parkin describes the mechanisms of memory and the factors that affect remembering and forgetting. Then developmental memory is discussed, covering early memory — from memory in the womb to memory later in life for adults over 65 years (Chapter 3). In Chapter 4, Parkin describes the techniques used to measure memory, from brain scans to test batteries, and in Chapter 5, the causes of memory loss are discussed. These causes could be permanent, such as those caused by head injury, or temporary, such as those resulting from drugs. Then Parkin describes how we should understand and cope with memory loss, as well as offering some practical tips for helping those caring for someone who has memory loss (Chapter 6). Finally, in Chapter 7, Parkin discusses the fallibility of memory, and in particular the well-known misinformation effect in eyewitness testimony, the formation of false memories, and the suggestibility of children's memories.

The book is designed for "the professional who needs to know more about memory than the pop book provides but feels daunted by an academic text." Specifically, this book targets those who need to know about memory in their professional capacities such as lawyers, psychotherapists, and social workers. Parkin does not try to cover all the issues in depth, but attempts to give a succinct summary, which will allow professionals to follow up any important

or interesting points using the references at the end of each chapter as a starting point.

Memory: A Guide for Professionals covers a wide range of important topics. One of the best features of the book is its applied focus. Although basic memory theory is covered (encoding, storage, retrieval in short- and long-term stores), which is necessary to understand many of the applied aspects of memory, the focus is very much on real-world phenomena. In most of the chapters, Parkin discusses laboratory research findings and what these findings mean in terms of people's everyday ability to remember and to forget information. Although this book is aimed at professionals, it will also appeal to a more general audience as it covers questions that are not specific to a particular profession but would interest most informed readers. For example, the book asks whether people can remember information that they heard while under a general anesthetic, and how people can stop their memory from declining as they get older.

The book is well written with a clear, easy-to-understand message. Its structure is logical, which makes it highly accessible to those without a background in memory. Indeed, the main points of each chapter are summarised in a bullet-point list. However, one potential problem with the book is that it tries to be too many things to too many people. By covering a lot of information in not-too-much depth, it necessarily overlooks some complexities in memory literature; for example, implicit memory, repression, and false memory. For people working in an applied context, such as forensic psychology, who really need more in-depth information about memory, this book might not be as useful as scientific articles or books focused on specific memory issues. Relatedly, by aiming to provide a book that is relevant across professions, Parkin has limited space remaining to focus on information relevant to just one of those professions; for instance, psychologists or lawyers. Although each chapter contains further references that a professional can seek out, it might have been more useful to include all the information — or as much as possible — in one text rather than directing busy professionals towards other sources.

As a first attempt to fill the large gap between academic and lay books on memory, Parkin's *Memory* is a great starting point both for professionals needing to know more about the subject of memory and for interested laypeople.

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**Essentials of Private Practice: Streamlining Costs, Procedures,
and Policies for Less Stress***

Holly A. Hunt

London: W.W. Norton & Co. 2005. \$US18.95, paperback

Western psychologists in private practice are generally working harder and earning less than they did years ago, due to managed care pushing out higher paying insurance, panels closing, contracted fees dropping, and a failure of private health care to adequately fund client sessions. Holly Hunt was in this position for ten years when working in a group practice, before deciding to go solo in California. In *Essentials of Private Practice*, she shares the strategies that she found to be useful in increasing her efficiency and eliminating unnecessary costs.

Having had a private practice in England and now the USA, I approached this book with two questions in mind: (1) to what extent were its suggestions relevant to British and other practitioners in Western countries such as Australia, New Zealand and South Africa?; and (2) what would I change about my own practice as a result of reading it? The promises of feeling less stressed, making more money, and getting home at a reasonable time were also very alluring!

The nine chapters in this book are organised along three main strategies: lowering overhead expenses, simplifying daily procedures, and implementing efficient client policies. Hunt's advice is very practical, covering issues such as how best to choose your office location, handle calls, bill for services, and prevent bad debt accruing. To the extent that dealing with insurance, late cancellations, and "no shows" are often the most stressful aspects to private practice, the chapters dealing with these issues were particularly welcome (e.g., "Streamlining for the First Appointment").

In fact, I wish I had read this book before launching my own practice 12 months ago, as I now find myself in some of the difficult situations that Hunt warns us against. For example, as I did not ask all the right questions before our first appointment, I had to bill a client for \$US650 after my claim to her insurance company was denied. I have also been too lenient with "no shows" and late cancellations, causing me to lose income and feel annoyed.

The short answer to my first question above is that, barring Hunt's advice on getting medical insurance, virtually everything in this book is relevant to any psychologists venturing into private practice. To the second question, I have decided to: have 45 minute instead of 50 minute appointments; collect fees at the start of each session instead of at the end; get more information

* This review first appeared in *The Psychologist* (Vol. 18, No. 6, 2005).

from insurance companies from the start; review my cancellation policy during the first contact with clients and be firmer in enforcing it; alter my greeting on my answering machine; and have new clients come early to their first appointment to fill out paperwork instead of sending it to them.

The only omission from this very useful book is advice on marketing and making use of free business advisory services.

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The Carlstedt Protocol: Science-Based Sport Psychology

Roland A. Carlstedt

New York: The American Board of Sport Psychology. DVD: Athlete Version: \$US36.00; Practitioner/Educator Version: \$US68

The following information* is provided about this new DVD as the editor would like an ASH member to review it for practice purposes in Australia. Please contact the editor of the AJCEH if you work in the area of sports enhancement utilising hypnosis and if you are willing to review the DVD.

The Carlstedt Protocol: Science-Based Sport Psychology is a DVD that presents a systematic and evidenced-based approach to athlete assessment and intervention. It provides practitioners with a comprehensive practice template that takes applied sport psychology to a new level of sophistication, one that is based on a solid peer-reviewed theoretical foundation and supported by potent data emanating from field tests of the methods and procedures advanced in this film.

If sport psychology is to emerge as a credible and necessary component of the performance enhancement equation it must advance beyond simplistic approaches to player evaluation and mental training. It must adapt and integrate instruments and procedures that offer practitioners insight into mind-body dynamics that mediate psychological performance and, importantly, test the efficacy of mental training interventions. Hybrid approaches that largely centre on visualisation must be replaced by highly individualised mental training methods that can be documented and analysed relative to their potency.

*This overview was first published in the American Board of Sport Psychology *Newsletter* (Vol. 1, No. 2, 2005), www.americanboardofsportpsychology.org, and is reprinted here in a slightly modified version with permission.

This film shows applied sport psychology practised on the cutting edge, an integrative approach that practitioners and students in the American Board of Sport Psychology certification programs learn to implement. It presents a viable evidence-based practice model that takes sport psychology into a new realm, one that is guided by individual, data-driven and systematised approaches that most practitioners welcome. Unique to the protocol is an internet-based test centre that allows practitioners to tap into a normative database on athlete neurocognitive functioning as well as analyse psychologically mediated heart rate variability trends (psychophysiological markers of peak performance) by uploading data that can be easily acquired using various heart rate monitors).

In this film, by Dr Roland A. Carlstedt, viewers will be exposed to:

1. Assessment of Primary Higher Order Psychological Factors using the Carlstedt Subliminal Attention, Reactivity, Coping Scale and related tests to measure an athlete's level of hypnotic susceptibility, neuroticism, and repressive coping.
2. Neurocognitive testing using the Brain Resource internet-based test battery for assessing subliminal brain responses (<http://www.americanboardofsportpsychology.org/Default.aspx?tabid=832>)
3. In-the-laboratory psychophysiological stress testing with video stimulus/stress paradigm.
4. Quantitative EEG (qEEG, brain mapping) using the Brain Resource Paradigm for assessing subliminal brain responding.
5. On-the-playing-field assessment of brain responding using blue-tooth based wireless EEG: measuring actual brain responses come crunch time.
6. On-the-playing-field assessment of heart rate variability, which is a powerful measure of reaction to stress.
7. Actual competition wireless monitoring of heart activity and post-competition heart rate deceleration analysis.
8. Critical Moments analysis: an objective method to analyse how an athlete performs during critical moments.
9. In-the-field Technical and Focus Threshold analysis: used to analyse mind-body-motor control and ability to concentrate during practice and competition.
10. Mental Training as a function of Athlete's Profile of Primary Higher Order Factors, including:
 - (a) *Heart Rate Variability and RSA biofeedback: used to regulate intensity and focus.*
 - (b) *Neurofeedback using Carlstedt Frontal Lobe Protocols: a means of directly shaping brain wave activity associated with peak performance components*

such as attention/focus, motor control and intensity.

- (c) *On-the-field Glasses-Laterality manipulation training: teaches an athlete to induce immediate shifts in brain activation that have been found to underlie transition from strategic planning to perceptual pre-action preparation; left to right brain shift facilitation and relative shut-down or idling of the frontal lobes which can interfere with focus; keeping intrusive thoughts at bay.*
 - (d) *Active-alert hypnosis: used with athletes who are high in hypnotic susceptibility to intensely focus and prime motor or technical responses while shutting out intrusive thoughts and external distracters*
 - (e) *Mental Imagery per Carlstedt Protocol: special mental imagery protocols customised to an athlete's profile and time demands of a sport.*
 - (f) *Tactile Motor and Technical Learning: using motor learning principles to consolidate training and technique into long-term motor memory; used in athletes with most negative psychological profile to override mental influences; strength and confidence though dominating physical and technical ability.*
 - (g) *Motor and Technical Control Threshold Training: using psychological learning principles to greatly increase mind-body control*
 - (h) *On-the-field Focus Threshold Training: same as (g) to enhance focusing ability.*
 - (i) *Cognitive-behavioural methods-per Carlstedt Protocol: so-called "talk therapy" to augment all other mental training methods.*
11. **Outcome or Efficacy Testing:** Investigation of Effects of the above Mental Training methods: A critical component of the Carlstedt Protocol designed to test whether assessment is accurate and an athlete is benefiting from mental training; it is rarely, if ever, used by the vast majority of practitioners; vital to the credible practice of sport psychology.
 12. **Comprehensive Athlete Database creation and management:** documenting assessment and training measures over time; databases are used for comparative purposes.
 13. **Psychological performance statistics:** statistics on the mental game that can be used to document psychological performance in real time, game to game, like with regular statistics such as batting average.
 14. **Comprehensive Report:** the culmination of a complete analysis of a player's mind-body motor performance.

INFORMATION FOR AUTHORS

1. Contributions should conform to the style outlined in the *Publication Manual of the American Psychological Association* (5th ed.; 2001), except that spelling should conform to *The Macquarie Dictionary*. Page references in the following notes are to the *Publication Manual*. The attention of authors is especially drawn to the organizational overview in the fifth edition (pp. xiii–xxviii).
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3. Title page (pp. 296–298) for the manuscript should show the title of the article, the name(s) and affiliation(s) of the authors, and a running head. The bottom of the page should also include the name and address (including postal code) of the person to whom proofs and reprint requests should be sent.
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